Exploring Anti-colonial Struggles in Nursing: A Situational Analysis of Indigenous Homelessness and Community Health Nursing

Julie Ella Williams

A dissertation submitted in partial fulfillment for the degree Doctor of Philosophy in Nursing

University of Ottawa

School of Nursing

Faculty of Health Sciences

Table of Contents

Dedication

F*or Indigenous people suffering through homelessness all across Turtle Island and for the people who have died as a direct result of homelessness and racist settler policies—I dedicate this work to you and your families. You are loved.*

Acknowledgments

Acknowledging land and relationships…

To begin, I respectfully acknowledge that the land where I grew up, the provinces and territories in Canada where I have worked, and the places that I have traveled all across Turtle Island are (always have been and always will be) Indigenous lands. The home where I currently live and raise my family is located on the traditional, unceded and un-surrendered Territories of the Algonquin Anishinaabeg. I recognize the suffering of First Nations, Inuit and Metis all across Turtle Island that are living in homelessness. They motivated this work and the people I have met taught me so much about how to be a nurse. Acknowledging Indigenous land and declarations of settler privilege easily becomes performative and empty. Minimizing this risk requires speaking with courage, which by definition comes from the heart. Being vulnerable is inseparable from courage and an acceptance that we are all capable of being wounded. The images below communicate things about my relationship with Indigenous Peoples and their traditional territories. These images also represent things that I value most and that have shaped me into who I am. Things such as a home

built with love, spending time in nature and being surrounded by family are valued by people all over the world and represent part of our shared humanity. At times, I have taken these things for granted. For Indigenous people experiencing homelessness access to these things are virtually non-existent. Settlers rarely think about the ways our unfettered access to Indigenous territories causes human harm. Restoring Indigenous sovereignty is our path forward to ensure that *all* Indigenous people also have unfettered access to the things you see here, which are quite simply basic human rights.

A huge thank you to everyone…

I want to thank everyone that supported me in reaching this milestone. I could not have done it without the generous support, love, and kindness of so many mentors, colleagues, friends, and family along the way. Firstly, a very big thank you to all of the harm reduction nurses that participated in this research. This dissertation would not exist without you. I am extremely grateful for your time and effort to attend interviews. Sharing your thoughts on this topic took courage. I also want to thank all of the organizational leaders that supported my research, allowed me to conduct interviews on-site and helped me network. Additionally, I want to thank everyone who contributed to my learning, especially my supervisor, committee members and examiners for all their time spent reading, sharing their valuable knowledge, and providing extensive feedback.

To my examiners, Dr. Lisa Bourke Bearskin, Dr. Mwali Muray, Dr. Brandi Vanderspank, and Dr. Veldon Coburn, all of your feedback was incredibly generous and you made what could have been an intimidating defense process into a welcoming environment, an engaging conversation and an opportunity to continue to learn and strengthen my work. My external examiner, Dr. Lisa Bourke Bearskin, you were incredibly generous with your time, sharing of insider knowledge, and meaningful feedback. It was also incredibly kind of you to share with me your extensive list of resources about Indigenous nursing, relational ethics, and cultural safety. I am more than a little in awe of your work and it was an honor that you agreed to be part of this process. Dr. Mwali Muray,

thank you for your unflinching critique of problems of silence that simply can't be ignored. You speak with conviction and compassion. Dr. Brandi Vanderspank, you were with me for my masters of nursing journey and your feedback and knowledge about qualitative research and reflexivity was always insightful. It was an honor to re-connect for this final hurdle to complete my PhD.

I am also extremely grateful for the support of my committee members, Dr. Veldon Coburn, Dr. Wendy Gifford and Dr. Joanna Binch. You each brought something incredibly important to my project and your unwavering support truly made a difference to me persevering with my studies through many challenging times. Veldon, you always made the time to hear about my trials and tribulations and had my back when I needed it most. You strengthened my understanding of Indigenous rights, politics, and critical social theory. Your collaboration with all of us settler nurses has pushed our thinking in new directions. Wendy, you have been a steadfast support since the earliest days of my masters. Your encouragement to turn the microscope around and focus on nurses changed the course of this research. Joanna, your pragmatic get-it-done approach and on-the-ground support was just what I needed to keep this project on track and on time. Your knowledge of harm reduction nursing and Ontario homelessness was also incredibly valuable.

To my supervisor, Dr. J Craig Phillips… I honestly don't know where to begin. You have walked this journey with me since the beginning and supervised my work throughout both my master's and PhD. You have stood by me through some incredibly challenging and difficult times. We have also had so many engaging conversations, joyful moments and heartfelt laughs over the years. You always push me to think about things differently, while providing gentle guidance and the space to make mistakes, learn and grow. You encouraged me to think big picture about systems, healthcare, and human rights. You have patiently read endless iterations of my thesis, which was not a short or easy endeavor given my 'prolific' writing style and the complexity of this work. I could not have asked for a better supervisor, friend, and mentor.

I am incredibly grateful for the support of friends and family. To my friends in the neighborhood, classmates, and work colleagues at OICH, thank you for all the walks, coffees and chats about school, work and life. To my children, Ella, Jack and Lily, I have been in graduate school for what feels like your entire childhoods. You are kind little (and not so little anymore) people that continue to love and inspire me. You were patient even when I was mentally elsewhere, for example, while you were trying to tell me about your day or eating appetizers from a box for supper! Despite the challenges, I hope that having a mom in school inspires a life-long love of learning and the confidence to pursue your dreams. To my husband Dave, you have taken up the lion's share of cooking and listened to my feminist complaints about the patriarchy. You have been my sounding board, buffer, and reality check when I needed to get my head out of the books and back into living. I could not have done this without your love and support.

To my parents, Linda and Ross, you have always been there for me and my brother, you are both amazing parents that raised us to be kind, work hard, and have a little grit. To my brother, I couldn't wait for you to leave home and now I wish that we could see each other more often. To my mom, with your 50 years of shift work at the Sundre General hospital, you were the impetus to me becoming a nurse (even though you told me not to) and my inspiration to change the system from within and always value bedside care as the bedrock of nursing. For my dad, who passed away unexpectedly before he could see me complete this PhD, your work to build community, teach industrial arts, coach biathlon, organize canoe club, and volunteer with basically everything at the high school and in the community, was inspiring to so many people. You were always ready to lend a hand to your family, friends, and neighbors with whatever they needed, especially if it involved breaking out your tools. You were the best listener and my original sounding board. I miss you always, but especially when comes time to celebrate the major milestones and little moments in life.

Abstract

Research Problem: Indigenous homelessness is rooted in colonialism and has profound impacts on health and wellbeing. Nurses encounter Indigenous people experiencing homelessness in their community health and harm reduction work, and yet little is known about how nurses struggle against colonial oppressions. **Study Aim:** The aim of this study was to critically examine how settler colonialism is embedded in nursing and how this influenced community nursing practices in the area of urban Indigenous homelessness. My research focused on community health and harm reduction nurses (CHNs) that primarily work with urban homeless communities and provide direct client care. **Theory and Methods:** My chosen method was Situational Analysis (SA), which is firmly located in a critical paradigm. One of the strengths of SA and part of my rationale for using this method was to provide an in-depth relational ecological overview of systems, structures and circulating discourses impacting nurses' actions. Therefore, this thesis tacks back and forth between the niche of CHNs working in a medium sized city in Ontario and the broader situation of Ontario and Canada. My theoretical framework was rooted in feminist and Indigenous strands of relational ethics. I also draw on intersectionality, critical race, and anti-colonial theories. I conducted interviews with CHNs and together we covered much ground in relation to Indigenous homelessness. I also analyzed extant discursive data including websites and news media articles. **Key Findings**: I began with an analysis of racist policies at the intersections of harm reduction and homelessness. I described circulating discourses and harm reduction backlash. I reviewed websites of nurse regulatory colleges and nursing associations to look for progress on the Truth and Reconciliation Commission (TRC) Calls to Action. Cultural competency/safety were key frameworks found during this review. However, these frameworks may have limited effect against racism and CHNs noted considerable confusion among these

concepts. In the interviews, leadership and organizational support emerged as essential (dis)enablers of CHNs actions. CHNs also described some promising practices, and I situated these findings within the overall progress on the TRC Calls to Action, nursing ethics, and Indigenous rights. Internal struggles among CHNs included their abilities to see racism and overcome silence. Important relational practices included narrative elicitation, bearing witness, suspending judgment, assuming a learner stance, and shared decision making. CHNs also described how they engaged in systems navigation, care coordination and tremendous amounts of advocacy to ensure that clients had equitable access to care. However, CHNs struggled to engage in higher levels of advocacy and advocacy *for* people rather than *with* them was common practice. Sharing stories were essential to build trusting relationships and the concept of narrative care holds promise as an anti-oppressive framework for CHNs harm reduction practices. Healing centered engagement may also be an important framework to re-orient nursing practices towards community level healing and taking action with Indigenous people experiencing homelessness. Indigenous worldviews and relational ethics are essential frameworks for anti-oppressive nursing praxis and anti-colonialism.

Keywords: Nursing, Homelessness, Harm Reduction, Community Health, Cultural Safety, Relational Ethics, Indigenous Rights, Racism, Settler Colonialism, Anti-Colonialism

Reader Caution: This thesis contains discussions about colonialism, anti-Indigenous racism, and negative stereotypes about Indigenous Peoples and substance use stigma that some readers may find distressing. I do not intend to perpetuate harm or to be gratuitous in my inclusion of certain words or phrases. However, some readers that are unfamiliar with Canada may also be unfamiliar with anti-Indigenous stereotypes that Canadian settlers perpetuate. I felt that it was important to acknowledge these stereotypes and the harmful language that unfortunately continues to exist in Canadian society so that it can be deconstructed and traced back to its roots.

Author's Note About Format: This monograph thesis narrates the story of my research and demonstrates my learning as a graduate student. The story of racism and colonialism is complicated. A series of articles would not have allowed me to weave together the bigger picture with the depth I desired. My thesis reflects the complexity of my topic, and the theories and methods that I used to explore it. I also felt it necessary to disrupt a western (colonial) scientific and positivist writing style. For example, I do not follow a rigid framework of introduction, background, theoretical framework, methods, findings, discussion and conclusion. I weave the story of my research findings together with theory and background throughout each chapter. This research is conducted within a critical feminist paradigm, as such I am an integral part of the research methods and inform knowledge development. No research is inherently unbiased. I made decisions (based on my values, perspectives, and experiences) to pursue certain lines of inquiry over others, which ultimately may have influenced my conclusions. I acknowledge when I may be presenting a one-sided account and why. Therefore, my personal reflections are not limited to a single positionality statement or section on reflexivity in the methodology. I am grateful for this opportunity to share my research in this format.

List of Abbreviations

Aboriginal Nurses Association of Canada (ANAC) (name changed to CINA)
Alberta (AB)
Black, Indigenous, and Person of Color (BIPOC)
British Columbia (BC)
British Columbia College of Registered Nurses and Midwives (BCCRNM)
Canadian Association of Nursing Schools (CASN)
Canadian Council of Registered Nurse Regulators (CCRNR)
Canadian Indigenous Nurses Association (CINA) (formerly ANAC)
Canadian Nurses' Association (CNA)
Canadian Registered Nurses' Exam (CRNE)
College of Nurses of Ontario (CNO)
Community Health Nurse (CHN)
Community Health Center (CHC)
Corona Virus Disease (COVID 19)
Critical Race Theory (CRT)
Diversity, Equity and Inclusion (DEI)
Electronic Medical Records (EMR)
Emergency Department (ED)
Entry-Level Competencies (ELC)
First Nations Health Authority (FNHA)
Grounded Theory (GT)
Harm Reduction Nurses' Association (HRNA)
Health Care Practitioner (HCP)
Hepatitis C Virus (HCV)
Homelessness, Addiction, Recovery and Treatment (HART)
Human Immunodeficiency Virus (HIV)
International Council of Nurses (ICN)
Manitoba (MB)
Members of the National Assembly (MNA)
National Inquiry into Murdered and Missing Indigenous Women and Girls (MMIWG)
National Council Licensure Examination (NCLEX)

New Brunswick (NB)
Newfoundland and Labrador (NF)
Non-Insured Health Benefits Program (NIHB)
Northwest Territories (NT)
Nova Scotia (NS)
Nunavut (NU)
Ontario (ON)
Ontario Disability Support Program (ODSP)
Ontario Works (OW)
Opiate Agonist Therapy (OAT)
Overdose Prevention Site (OPS)
Prince Edward Island (PE)
Registered Nurse (RN)
Royal Canadian Mounted Police (RCMP)
Royal Commission on Aboriginal Peoples (RCAP)
Safe Consumption Site (SCS)
Saskatchewan (SK)
Sexually Transmitted and Blood Born Infections (STBBI)
Situational Analysis (SA)
Social Determinants of Health (SDH)
Total Equities Competencies (TEC)
Trauma Informed Care (TIC)
Trauma and Violence Informed Care (TVIC)
Traumatic Brain Injury (TBI)
Truth and Reconciliation Commission (TRC)
Tuberculosis (TB)
Two-Spirit, Lesbian, Gay, Bisexual, Trans, Queer (2SLGBTSQ+)
Universal Declaration of Human Rights (UDHR)
United Nations (UN)
United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)
United States (US)
World Health Organization (WHO)
Yukon Territories (YK)

List of Tables and Figures

Chapter One: Introduction

> *Currently, the situation, and very often the plight of Indigenous peoples, should act as a mirror to mainstream Canada. The conditions that Indigenous peoples find themselves in are a reflection of the governance and legal structures imposed by the dominant society. Indeed, what the mirror can teach is that it is not really about the situation of Indigenous peoples in this country, but it is about the character and honor of a nation to have created such conditions of inequity. It is about the mindset of a human community of people refusing to honor the rights of other human communities. The gaze staring out from the mirror is the mindful look of Indigenous humanity standing as it is with substantial heritage.*
>
> *Willie Ermine – Cree Scholar and Ethicist (2007, p. 200)*

Indigenous Peoples are disproportionally burdened by homelessness in Canada because of colonization and racist government policies (Bono, 2019; Kidd et al., 2019; Patrick, 2014; Schmidt et al., 2015; Thistle & Smylie, 2020). Indigenous homelessness is one of the most brutal manifestations of settler colonialism, the violent dispossession of Indigenous Peoples from their homes, communities, lands and cultures, and it exemplifies problems related to systemic racism in Canada. Indigenous homelessness constitutes a significant barrier to accessing healthcare and contributes to health disparities (Oelke et al., 2016; Schmidt et al., 2015; Thistle & Smylie, 2020). Stigmas associated with homelessness, poverty, mental illness, substance use, and street involvement intensifies problems of anti-Indigenous racism in healthcare. Exposing racism in healthcare through Indigenous Peoples' stories and perspectives is crucial to understanding the gravity of the problem. But racism is insidious, it goes beyond egregious displays of racist comments and behaviours by nurses (Bell, 2024; Gebhard et al., 2022; Horrill, 2021). Settler Canadian nurses must take a hard look in the mirror as Willie Ermine so eloquently described.

In this introductory chapter, I begin with an overview of the research problem. Next, I review the literature on settler colonialism in nursing and anti-Indigenous racism in healthcare more generally. I introduce a relational view of Indigenous homelessness and anti-colonialism as

a radical intersectional lens requisite to understand systemic racism. I identify limitations of extant research, which clearly identified a need for further research into how community health nurses (CHNs) enact anti-oppression approaches in their daily work with Indigenous people experiencing homelessness. Following my literature review, I provide a brief overview of my theory, methods, and research questions. I conclude by laying out the contents of my dissertation.

Research Problem

Systemic anti-Indigenous racism and structural violence underpin settler colonial society, invade health care policy, and cause health inequities (Allan & Smylie, 2015; Browne, 2017; Phillips-Beck et al., 2020; Viens, 2019). More than sufficient evidence exists to conclude that racism exists in nursing and within all areas of healthcare. Nursing action against anti-Indigenous racism is inadequate. Considerable research and reports documented blatant anti-Indigenous racism ongoing for years in healthcare (Allan & Smylie, 2015; Benoit et al., 2019; Browne, 2017; Government of British Columbia, 2020; Horrill et al., 2019; Kitching et al., 2020; Phillips-Beck et al., 2020; Viens, 2019). Importantly, this research has exposed problematic nursing actions from the patient perspective, typically in acute care settings. Moreover, racism is often much more insidious than blatant. Unfortunately, the covert nature of many forms of racism makes it more difficult to study. However, this research is critical to first identify and then act against systemic racism and other interconnected oppressions rooted in colonialism.

Settler colonial systems and structures are at the root of Indigenous homelessness and health inequities (Kidd et al., 2019; Thistle, 2017). Manifestations of homelessness, including street involved behaviours and substance use, are more visible to nurses than the colonial systems and structures that continuously cause trauma and harm among Indigenous Peoples (Thistle & Smylie, 2020). CHNs that work in harm reduction are on the front lines of immense

social suffering related to homelessness. On a daily basis they witness trauma caused by harmful social policies. Given high rates of Indigenous homelessness in urban centers across Canada (Government of Canada, 2023), it is likely CHNs encounter many Indigenous people in their harm reduction work. Yet, little is known about how CHNs understand Indigenous homelessness, and enact cultural safety and anti-racism in their nursing practices. Research into social worlds of CHNs provides an opportunity to glean rich insights into anti-oppressive nursing practices and may help identify actions that perpetuate, uphold, and/or challenge oppression.

It is important to note that my study examined nurses' actions and not Indigenous Peoples' experiences of homelessness. I explored CHNs' relational practices within the broader sociopolitical system that perpetuates Indigenous homelessness and the situational elements that influenced their (in)action against colonialism. The same colonial systems and structures that perpetuate Indigenous homelessness also uphold systemic racism in healthcare, deter access to care, and cause health inequities. Therefore, concurrent problems of Indigenous homelessness and anti-Indigenous racism in nursing are highly related. I attempt to make the connections between Indigenous homelessness and racism in healthcare more explicit in my relational ecological overview of the situation. For the purpose of positioning my research into the gaps in extant nursing literature, I begin with a review of research on anti-Indigenous racism in nursing and healthcare before I move into an overview of Indigenous homelessness and harm reduction.

Research Limitations and Gaps

Indigenous persons from all walks of life report negative experiences in healthcare settings, which are well documented in the extant literature (Benoit et al., 2019; Kitching et al., 2020; Phillips-Beck et al., 2020). This research typically focused on acute care. Two important gaps in research, which my study sought to address, included nurses' perspectives of anti-

Indigenous racism, and studies within community health and harm reduction settings. Stigma associated with street involvement, sex work, poverty, substance use, and homelessness are deeply entwined with some of the most harmful stereotypes about Indigenous Peoples (e.g., drunken Indian, lazy, unemployed, taking advantage of taxpayers, sexually promiscuous women, bad mothers, criminally deviant; Benoit et al., 2019; Thistle, 2017). These racist stereotypes are prevalent among nurses and other healthcare practitioners (HCP) and have resulted in avoidable deaths in healthcare (Government of British Columbia, 2020; Kamel, 2020; McCallum et al., 2021; Viens, 2019). Indigenous people may encounter these stereotypes in healthcare regardless of whether they are actually homeless and use substances or not. Therefore, research exploring intersections between Indigenous homelessness and racism in healthcare has potential to improve our understandings of cultural safety more generally.

Considerable research has focused on Indigenous Peoples' perspectives about accessing healthcare (Allan & Smylie, 2015; Benoit et al., 2019; Browne, 2017; Horrill et al., 2019; Kitching et al., 2020; Phillips-Beck et al., 2020; Viens, 2019). This research identified factors that influenced Indigenous people's encounters with nurses, such as individual and collective trauma, anti-Indigenous racism, mistrust of the healthcare system, sociopolitical context, and nurses' involvement with historical harms (e.g., nurses' roles in residential schools, Indian Hospitals, tuberculosis sanatoriums, harmful 'scientific' medical experimentation, state child apprehension, and forced sterilization, which are poorly studied, beyond simply acknowledging the mistrust that they caused; Symenuk et al., 2020). The factors listed above are all barriers to developing therapeutic relationships, deter access to care, and cause harm to Indigenous people seeking healthcare (Horrill et al., 2022; Jennings et al., 2018).

Despite considerable research and government inquiries that have highlighted structural

violence as a primary cause of substantial health disparities between Indigenous Peoples and settler Canadians, systems levels changes are slow. For example, the four thousand page final report of the Royal Commission on Aboriginal Peoples (RCAP) released in 1996 set out a 20 year agenda for implementing the 440 recommended changes, and at the conclusion of this timeline not much had changed (Troian, 2016). Released in 2015, the final report of the Truth and Reconciliation Commission (TRC) set out 94 Calls to Action, and regrettably completion of these calls are progressing at a "glacial pace" (Jewell & Mosby, 2022, p. 14). Horrill argued, and I agree, that "structurally violent conditions experienced in the everyday lives of Indigenous Peoples constitute a serious, yet remediable, concern. Within their practice[s], nurses witness this structural violence, and at times are complicit actors, enabling or maintaining it through unequal relations of power, social interactions and institutional processes" (Horrill, 2021, p. 1). Researchers have undertaken important efforts to expose the widespread problem of racism and harms inflicted on Indigenous Peoples by HCPs (e.g., Benoit et al., 2019; Benoit et al., 2003; Goodman et al., 2017). Unfortunately, simply exposing problems have not led to coordinated, collective, and effective nursing action against systemic racism. Indeed even action among individual nurses may be limited, which suggests that some theories of change may be flawed. Re-presenting stories of harm through research do not always motivate or cultivate effective actions against racism and colonialism (Tuck, 2009).

Exposing Settler Colonialism in Nursing

Nurses have perpetuated colonization and inflicted violence and harm against Indigenous Peoples and nurse researchers must also respond to the call for truth as an important part of reconciliation (Symenuk et al., 2020). However, the ways in which nurses participated in colonialism are not well documented in the academic literature and the nursing profession has

yet to fully acknowledge this harm. Symenuk et al. (2020) conducted a systematized search and narrative review of nursing research dedicated to uncovering nurses' involvement in past and present colonial harms in five areas: Indian Hospitals, Indian Residential Schools, state child apprehension, Missing and Murdered Indigenous Women and Girls, and forced sterilization. Symenuk at al. (2020) found that since the TRC in 2015, nursing research has not examined nurses' involvement in any of these five areas. Canadian healthcare systems maintain connections with this historical violence and settlers continue to perpetuate violence against Indigenous Peoples on multiple levels from individual to systemic in government and society.

Al-Chami, Gifford and Coburn (2023) argued that nursing theory is not a-political, but also noted that in-depth analysis of nursing theory to expose underlying political ideology is rarely undertaken by nurse researchers. For example, Florence Nightingale is celebrated globally as one of nursing's most influential early scholar and theorist. She also worked for Britain's war office and participated extensively in colonialism (Stake-Doucet, 2020). Archival documents are requisite to uncovering nurses' roles in colonialism. Some of these historical documents in government archives may be difficult to access. However, Nightingale produced a report for her employer around 1863 titled *Sanitary Statistics of Native Colonial Schools and Hospitals,* which is publicly available on the internet. Yet, it still has not been subjected to fulsome analysis by nurse scholars. Moreover, despite the overt racism in Nightingale's report some of the authors citing her report still uncritically praised Nightingale as a nursing hero (e.g., McDonald, 2010). Nightingale's report is discussed in more detail in chapter three.

Racism in Nursing and Healthcare

A recent systematic review that looked exclusively at nursing research on racism found that the bulk of empirical studies were qualitative and focused on describing experiences of

racism (Collier-Sewell, 2023). This review also noted that nursing literature did not have a strong theoretical framework to describe systemic racism. Theoretical understandings of racism tended to be at the individual level, which resulted in frequently highlighting problematic behaviours among individual nurses (Collier-Sewell, 2023). Bonilla-Silva (1994) noted a similar problem in social sciences that race researchers often did not define racism and when they did define it an ideological perspective predominated that racism was based on illogical beliefs and behaviours among individuals. He suggested that structural understandings of racism were lacking. More recently, Bonilla-Silva (2021, 2023) highlighted that academic work on systemic racism was rapidly proliferating, which suggests, based on Collier-Sewell (2023) systematic review, that nurse academics may be lagging behind in their study of systemic racism. An individual level focus suggests that racism is a problem among a few nurses and detracts from more radical changes that are requisite to eliminate systemic racism in healthcare.

Collier-Sewell (2023) also noted that nursing research tended to look at workplace experiences among Black, Indigenous, and Person of Color (BIPOC) nurses and nursing students and looked less frequently at experiences accessing care among BIPOC patients/clients. Researchers tended to rationalize their research because racism had not been explored in a particular situation (e.g., obstetrics, universities) and with a particular group of nurses, nursing students, or patients/clients (e.g., Black, Muslim). Collier-Sewell, (2023) argued this rationale risks perpetuating the notion that further data is needed to (dis)prove the existence of racism among various racialized peoples and in all areas of nursing. There is sufficient evidence that racism exists in all areas of nursing, impacts both nurses and patients, and that racism manifests differently against various racialized groups. Experiences of racism among BIPOC nurses are not directly related to my study, but this research draws attention to problematic behaviours among

White nurses. Although, racist comments are immensely hurtful, White silence surrounding racism was highlighted as one of the most pressing issues to address in nursing (Applebaum, 2013; Bell, 2024; Collier-Sewell, 2023; Dillard-Wright, 2022; Hantke et al., 2022; Iheduru-Anderson et al., 2021; McGibbon et al., 2014). Remaining silent is complicit with racism and it maintains White supremacist systems that perpetuate inequities (Kendi, 2019).

Collier-Sewell's (2023) review did not capture the large body of evidence that exposed anti-Indigenous racism in healthcare, in part because within this body of research the principle investigators may not be nurses and/or studies may not be framed as nursing research (Allan & Smylie, 2015; Benoit et al., 2019; Benoit et al., 2003; Goodman et al., 2017; Government of British Columbia, 2020; Kitching et al., 2020; TRC, 2015; Viens, 2019). Additionally, nursing research often explored discrimination against Indigenous Peoples in healthcare using a lens of colonialism or cultural safety rather than framing research questions around race and racism (Browne et al., 2016; Browne & Varcoe, 2006; Bucharski et al., 2006; Hunter & Cook, 2020; Richardson et al., 2017). Therefore, systematic reviews that use race and racism as key search terms may not locate all studies. Nursing research has explored experiences of violence and discrimination in healthcare among Indigenous Peoples in Canada (Andersen & Walter, 2013; Browne & Smye, 2002; Browne et al., 2016; Browne, 2017; Browne & Varcoe, 2006; Eaker, 2021; Hantke et al., 2022; Harry, 2014; Horrill, 2021; Horrill et al., 2019; Horrill et al., 2022; McGibbon et al., 2014). Research that takes a relational ecological approach is critical to understanding oppressive systems and structures (World Health Organization [WHO], 2010). However, in nursing this approach is not often undertaken and systemic and structural racisms are under-researched. Research has typically focused on experiences of more overt individual acts of racism (Collier-Sewell, 2023).

Nurses must dismantle colonial systems to eliminate racism in nursing and ensure equitable access to healthcare for all (Bourque Bearskin, 2011; Bourque Bearskin et al., 2020; Horrill et al., 2022; Hunter & Cook, 2020). As nurses, collectively, we must push past procuring more descriptions of blatant racisms and begin to expose the insidious and covert behaviours and beliefs that uphold systemic violence and racial inequities (Collier-Sewell, 2023). Although overt racist stereotypes about Indigenous Peoples still circulate in Canadian society around dinner tables and in hospital hallways, mainstream media and politicians are more likely to use racially coded language, at least in public (Budd, 2024; Johnston, 2020). Racially coded language is one of many insidious ways that intersecting forms of prejudice and discrimination rooted in White supremacy[1] evades being seen as racist. White racial behaviours such as White benevolence and color-blind racism, which are more covert forms of racism, are also just emerging into the focus of nurse researchers (Gebhard et al., 2022). I expand on some ways in which systemic anti-Indigenous racism is hidden in seemingly race neutral policies and the problem of White racial behaviours in more detail in chapter three.

Nursing research must move back and forth between both exposing problems and identifying solutions. Truth must come before reconciliation and exposing racism is critical. However, research that also explores positive nursing actions could lead towards more ethical and culturally safe nursing care. The bulk of empirical research on anti-Indigenous racism in healthcare focused on describing overt racist behaviours among individual HCPs in acute care

[1] The term White supremacy is contentious because it is associated with extremist movements (e.g., neo-Nazis) that unabashedly proclaim Whites are superior and often advocate for violence against BIPOC peoples. I use the term White supremacy despite the discomfort it may cause. I argue that it is an accurate term to describe what some people call Eurocentrism or ethnocentrism because Europeans were invested in creating a hierarchy whereby, they self-identified themselves as both White and as superior to all other peoples.

settings and the impact of these negative encounters at the level of individuals. Importantly, this research has exposed the widespread problem of culturally unsafe care and racism in healthcare. Fewer studies have examined nurses' perspectives about the care they provide to Indigenous Peoples (Browne et al., 2016; Horrill, 2021). Critical reflection on stories of culturally unsafe care and racism in healthcare may cultivate motivation for change, but unfortunately it doesn't provide a pathway towards exemplary care and understanding what constitutes culturally safe and anti-racist nursing practices (Hunter & Cook, 2020; McCubbin et al., 2013). Stories of racism in healthcare provide a clear picture of what not to do, but the absence of overtly bad practices does not constitute best practices.

Indigenous Homelessness

Homelessness disproportionally affects Indigenous Peoples as a direct result of traumatic colonial interventions such as residential schools, loss of culture, land theft, lack of support for children in foster care, systemic racism, and over-incarceration (Bono, 2019; Patrick, 2014; Thistle, 2017). Thistle (2017) described how racist settler discourses about substance use, poverty, and street involved behaviours often deny settler colonial violence as the root cause of Indigenous homelessness. Undoubtedly, historical injustices set in motion the conditions for Indigenous homelessness and health inequities. Europeans used notions of terra nullius (empty or vacant land) and White supremacist ideas about race and Christianity as justification for colonial expansion around the world that included land theft, slavery, exploitation, genocide and violent attempts to eliminate non-European worldviews, languages, and cultures (Coulthard, 2007; Loomba, 2015; Russell, 2020).

Canadian legal systems and sociopolitical structures, which include healthcare, maintain Indigenous disadvantages and settler advantages into the present day. Therefore, policy changes

that support Indigenous land claims and sovereignty and specifically begin to dismantle the interconnected systems of White supremacy, colonialism, and anti-Indigenous racism are requisite to ending Indigenous homelessness and achieving health equity (Anthony & Hohmann, 2024; Bono, 2019; Braimoh et al., 2023; Minich et al., 2011; Patrick, 2014; Thistle, 2017). Housing and healthcare are human rights (Olson & Pauly, 2021) and these rights are repeatedly violated for Indigenous Peoples in Canada (Jewell & Mosby, 2023; TRC, 2015).

Quantifying Homelessness. I cautiously present statistics about Indigenous homelessness keeping in mind the importance of situating these numbers in the history of colonialism. Statistics are, quite simply, evidence of systemic racism rooted in White supremacy. Systemic racism, assimilationist and segregationist policies, land theft, and intergenerational trauma all push high rates of Indigenous homelessness (Thistle, 2017). Rates of Indigenous homelessness vary across Canada. However, in all major Canadian cities Indigenous homelessness occurs at much higher rates than homelessness among the overall population in Canada, and rates are likely to be underestimated due to enumeration methods, and potential hesitations for people to self-identify as Indigenous (Oelke et al., 2016; Patrick, 2014; Thistle & Smylie, 2020). Some research, including aggregated point-in-time counts from urban centers across Canada, suggested the risk of homelessness for urban Indigenous Peoples to be 6-8 times higher than the general population (Belanger et al., 2013; Government of Canada, 2023). Unfortunately, aggregated statistics may obscure diversity and geographical differences.

Rates of Indigenous homelessness varied considerably depending on the location surveyed in point-in-time counts. For example, a snap shot from the The Canadian Observatory on Homelessness (n.d.) reporting of 2021/2022 point-in-time counts found that people experiencing homelessness that identified as Indigenous are estimated to account for 13% in St

Johns, 23% in Toronto, 33% in Vancouver, 34% in Ottawa, 54% in Edmonton, 68% in Thunder bay, 68.2% in Winnipeg, 79% in Regina, 91.5% in Yellowknife, and 99% in St. Albert of the total homeless population surveyed in those cities. Other community profiles (e.g., Montreal) did not report Indigenous homelessness statistics. Some point-in-time counts only surveyed people staying in shelters, which may skew results considerably towards underestimations of Indigenous homelessness because Indigenous respondents were less likely to access shelters than the other respondents in point-in-time counts across the country (Government of Canada, 2023; The Canadian Observatory on Homelessness, n.d.).

These rates may be increasing in some cities, including in Ottawa where I currently live. For example, in the City of Ottawa's 2021 point-in-time count 32% of people surveyed identified as Indigenous, this was an increase from the previous point-in-time count in 2018 when 24% of respondents identified as Indigenous (City of Ottawa, 2018, 2021). These changes may reflect an actual increase in Indigenous homelessness but may also have resulted in part from different enumeration strategies and/or willingness to report Indigenous identity. The overall population of Indigenous Peoples living in Ottawa may also have grown over the 3 years and the increase in Indigenous respondents in the point-in-time count may be related to urban migration patterns. The COVID 19 pandemic may have been responsible for some of the statistical changes as 14% of total respondents in 2021 reported their most recent housing loss was due to pandemic related issues (City of Ottawa, 2021). COVID 19 had differential impacts on Indigenous communities (Benji et al., 2021; Power et al., 2020; Rowe et al., 2020; Starblanket & Hunt, 2020), including increased risk of developing COVID 19 and increased vulnerabilities among urban Indigenous families to stressors (e.g., food insecurity, inability to cover rent and other essentials) during periods of illness and lockdowns (Arriagada et al., 2020) that may contribute to housing

vulnerabilities and loss. Pre-pandemic difficulties accessing harm reduction care were also exacerbated during COVID 19 (Barker et al., 2025; Christianson, 2024).

Canada-wide statistics suggested that Indigenous homelessness looks different compared to within the general population, for example, an aggregated report of point-in-time counts from across Canada found that compared to non-Indigenous respondents, Indigenous respondents were more likely to identify as women (40%) compared to non-Indigenous respondents (31%) (Government of Canada, 2023), suggesting the need for an intersectional lens. Indigenous respondents were also more likely to report substance use problems and both physical and mental illness compared to non-Indigenous respondents (Government of Canada, 2023). Importantly, these were simple descriptive statistics, and it is important to not draw causal links between substance use and Indigenous Peoples. These statistics highlight the importance of equitable access to harm reduction supports that are culturally safe and meet Indigenous people's needs.

Indigenous respondents were also less likely to access shelters and were more likely to be unsheltered or to be experiencing hidden homelessness (Government of Canada, 2023). Rates of unsheltered versus sheltered homelessness among the general homeless population also varied considerably by region with far more unsheltered homelessness in western and northern regions (33%) compared to central (17%) and eastern regions (19%) (Government of Canada, 2023). Lack of shelter (e.g., sleeping rough on the street and in encampments) has many negative health effects including exposure to the elements, which is a particular issue in Canada and can lead to death and disability (e.g., losing limbs to frost bite and death from hypothermia in Canada's cold winters or heat exhaustion and dehydration in summer; Goerdat, 2024; Kidd et al., 2021). Research in Australia suggested Indigenous women sleeping rough may also suffer a greater burden of poor health outcomes (e.g., cancer, heart disease, cellulitis, brain injuries, mental

illness) compared to men and non-Indigenous women sleeping rough (Box et al., 2022). Hidden homelessness (e.g., couch surfing) and sleeping rough may place people (particularly Indigenous women and 2SLGBTQ) at higher risk of violence, sexual exploitation, and coercion to exchange sex for shelter (Box et al., 2022; McKeown et al., 2004; Schmidt et al., 2015; Shahram et al., 2017). Therefore, disparities in shelter use are a determinant of poor health outcomes and highlight inequitable access among Indigenous people to potentially safer places to sleep. Point-in-time counts did not report reasons why Indigenous persons were less likely to access homeless shelters compared to non-Indigenous persons, but racism is a likely factor.

All of the above statistics suggest that nurses may experience challenges in connecting and building relationships with Indigenous people experiencing homelessness because shelters are an important point of contact to provide care (Paradis-Gagné et al., 2020; Pauly, 2014; Ungpakorn & Rae, 2020). These statistics highlight inequitable access to shelter-based healthcare, harm reduction supports and other social services among Indigenous persons experiencing homelessness. Access to mainstream healthcare, including attending outpatient appointments, typically depends on reliable access to phones or internet, which people often do not have when they are homeless and particularly when they are staying outside of shelters (Heaslip et al., 2021). Therefore, Indigenous people experiencing homelessness have inequitable access to healthcare more generally because they are more likely to sleep rough or couch surf compared to non-Indigenous people that are also homeless.

Indigenous Diversity. There is considerable diversity among Indigenous Peoples in Canada and Indigenous organizations have frequently problematized pan-Indigenous approaches to research, program, and policy development (First Nations Information Governance Centre, 2014; Inuit Tapiriit Kanatami, 2018). Similar to other cities' point-in-time counts, Ottawa's 2018

and 2021 homelessness reports categorized self-identification into four groups: First Nations with or without Status (45% in 2018, 40% in 2021), Inuit (23% in 2018, 34% in 2021), Métis (20% in 2018, 15% in 2021), and Indigenous Ancestry (12% in 2018, 11% in 2021). This data suggested that Inuit homelessness is growing in Ottawa despite representing a small proportion of the total population and that Inuit specific supports are essential. Inuit homelessness in Ottawa has been linked to medical travel and a lack of supports for people leaving remote communities (Bono, 2019; Minich et al., 2011; Pauktuutit Inuit Women of Canada, 2017).

Most point-in-time count reports clustered all four groups of people (First Nations, Inuit, Métis, Indigenous Ancestry) together into one group when presenting the majority of statistics including shelter use versus sleeping rough on the street. The category of Indigenous ancestry may have been intended to be more inclusive of people of mixed ancestry and allow for greater options for self-identification. However, it may also be controversial to include this category together with the three constitutionally recognized groups of Indigenous Peoples (First Nations, Inuit, and Métis). People of Indigenous ancestry may not have any connections to Indigenous cultures and communities and may not have faced colonial oppressions in similar ways to that of First Nations, Inuit, and Métis. Combining all 4 groups together could skew data towards underestimating certain issues, for example, people that identify as having Indigenous ancestry may access shelters at similar rates to White people.

Considerable cultural variation and nuance is lost even when data is separated out by these four groups because there is extensive diversity within and between Indigenous groups in Canada. Service providers in urban centers may encounter challenges to create culturally specific programing and research initiatives with people experiencing homelessness because there is greater diversity within most urban Indigenous populations compared to smaller more culturally

homogenous rural communities. For example, Ottawa is located on the traditional unceded territory of the Algonquin Anishinaabeg, but many Inuit, Métis and First Nations persons have traveled from across Canada and are currently homeless in Ottawa. According to the Statistics Canada (2016) census for Ottawa-Gatineau, there is considerable diversity among the First Nations population in Ottawa and a total of 67 possible responses for First Nations ancestry were included on the census. However, the vast majority (53%) of respondents identified as First Nations not included elsewhere (i.e., not listed as one of the ancestry options). The next most common responses were Mi'kmaq (11%), Algonquin (10%), Cree (9%), Ojibway (6%), and Mohawk (5%). Importantly, censuses typically do not enumerate persons with no fixed address and the census data above were collected from people living in private residences over 5 years ago. We cannot assume that these numbers are representative of Indigenous diversity within the homeless population in Ottawa today. Indeed, Indigenous persons relocating to Ottawa from other Nations may be more socially isolated and at risk of homelessness than Algonquin Anishinaabeg that are in closer proximity to home communities and potential social support networks. Dispossession of territory (i.e., land theft) through historic and ongoing colonization resulted in an Indigenous diaspora that contributes to Indigenous diversity and homelessness in Canadian cities (Anthony & Hohmann, 2024; Cooper & Driedger, 2018; Healey, 2016; Monchalin et al., 2020; Peters, 2005; Senese & Wilson, 2013). All of the statistics presented above are important because they illustrate the gravity of Indigenous homelessness, and they highlight that human rights violations and immense suffering are happening everyday among Indigenous Peoples in Canada.

Anti-Colonialism and Indigenous Paradigms

The role of health and social services in Canada's colonial history further impedes the development of trusting relationships between settler colonial nurses and Indigenous persons accessing care (Allan & Smylie, 2015; Benoit et al., 2019; Browne, 2017; Government of British Columbia, 2020; Horrill et al., 2019; Kitching et al., 2020; Phillips-Beck et al., 2020; Viens, 2019). Nurses historically had a role in colonialism (Symenuk et al., 2020), but colonialism is not confined to the past. Colonialism and White supremacy problematically continues into the present day in nursing (Al-Chami et al., 2024; Gebhard et al., 2022). Indigenous relational worldviews are essential to understanding Indigenous homelessness and must guide ethical pathways forward towards ending problems of systemic racism, homelessness, and inequity.

Relational Worldviews. Firstly, I emphasize the diversity of Indigenous cultures and my overview of relational worldviews are not intended to be a pan-Indigenous approach. However, commonalities among many Indigenous worldviews may help to situate relational ethics and relational understandings of Indigenous homelessness. Hart (2010), a Cree social worker, provided an extensive review of the literature to describe commonalities within many Indigenous paradigms including: 1) recognition of a spiritual realm (all living things have spirits and spiritual beings exist) that is interconnected with the physical realm, 2) the land is sacred, and of all life that the land sustains human beings are least important, 3) individuals enjoy great freedom because they put the needs of the community first, and 4) cultural knowledge is rooted in connections to traditional lands, ancestors, and communities. Local histories and knowledges are passed down over generations through oral storytelling traditions; therefore, "community cultivates spiritual energy and creates an environment for learning and practicing values and beliefs and the transmission of knowledge" (McCubbin et al., 2013, p. 356). Indigenous

knowledges and values provide guidance for respectful ways of being and surviving in harmony with all living and non-living things, which is grounded in a relational ethic (Barlo et al., 2021). Balance and harmony are essential for survival and this links back to respect for creator, cosmos, and earth—an holistic and ethical perspective that is the essence of wellbeing (Hart, 2010; Healey & Tagak, 2014). *Critical* Indigenous theories emphasize relational worldviews; but they also draw attention towards analyzing problems of colonialism and the need for decolonization.

Struggles Against Colonialism. At the root of decolonization is the return of Indigenous sovereignty over territory and resources (Tuck & Yang, 2012). Indigenous Territorial rights, sovereignty, and upholding treaty obligations are core actions requisite to ending Indigenous homelessness (Anthony & Hohmann, 2024; Braimoh et al., 2023; Thistle, 2017). However, systems and structures may also be decolonized including restoration and protection of Indigenous languages, traditional practices, customs, culture, health and healing practices, lifeways, ways of knowing, systems of governance, etc. Therefore, the nursing profession, which is bound up with colonialism (past and present) must also work towards decolonization (Al-Chami et al., 2024). Dene scholar Glen Coulthard (2007) argued

> any strategy geared toward authentic decolonization must directly confront… the multifarious ways in which capitalism, patriarchy, White supremacy, and the inherently totalizing nature of the state interact with one another to form the constellation of power relations that sustain colonial patterns of behavior, structures, and relationships… [S]hifting our attention to the colonial frame is one way to facilitate this form of radical intersectional analysis. (p. 20)

Based on Coulthard's radical intersectional analysis described above, I use the term anti-colonial struggles to include struggles against multiple intersecting oppressions rooted in colonialism

(e.g., racism, sexism, classism). Anti-racist struggles are synergistic with anti-colonial struggles (Fanon, 2007), and with feminist struggles because colonialism is indelibly bound with patriarchy (Coulthard, 2007; Loomba, 2015). Capitalism and classism, which are also rooted in colonialism, are directly related to homelessness among settlers and Indigenous Peoples alike. Therefore, anti-colonialism is an important lens to deconstruct problems of homelessness in general. Colonialism is not relegated to the past; it is actively promoted in settler society. Colonialism and anti-colonialism exist antagonistically in the present day and decolonization is not a linear movement forward—It too is a struggle (Loomba, 2015).

Relational Definitions of Homelessness. For the purpose of my research, I draw on the Aboriginal Standing Committee on Housing and Homelessness's (ASCHH, 2012) definition of Indigenous homelessness that is further explained by Jessie Thistle a Métis scholar with lived expertise of Indigenous homelessness.

> Indigenous homelessness is a human condition that describes First Nations, Métis and Inuit individuals, families or communities lacking stable, permanent, appropriate housing, or the immediate prospect, means or ability to acquire such housing… it is more fully described and understood through a composite lens of Indigenous worldviews. These include individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities. Importantly, Indigenous people experiencing these kinds of homelessness cannot culturally, spiritually, emotionally or physically reconnect with their Indigeneity or lost relationships. (ASCHH, 2012 as cited by Thistle, 2017, p. 6)

Within this definition the emphasis on relationships is notable and particularly that homelessness is characterized by lost relationships and erects barriers to reconnect in a holistic way, which supports a relational ethics approach to care and the theoretical framework of my study.

The Canadian definition of homelessness includes 4 types of homelessness: unsheltered, emergency sheltered, provisionally accommodated, and at risk of homelessness (Thistle, 2017). Thistle (2017) expanded on these 4 categories and further articulated 12 dimensions of Indigenous homelessness including: historic displacement homelessness, contemporary geographic separation homelessness, spiritual disconnection homelessness, mental disruption and imbalance homelessness, cultural disintegration and loss homelessness, overcrowding homelessness, relocation and mobility homelessness, going home homelessness, nowhere to go homelessness, escaping or evading harm homelessness, emergency crisis homelessness, and climatic refugee homelessness. Thistle (2017) highlighted that Indigenous homelessness is not a simple response to a housing affordability crisis, but rather is inseparable from more insidious problems of Indigenous dispossession from territory and culture.

Harm Reduction Nursing

Harm reduction is an important nursing approach for people experiencing homelessness and will be discussed in more detail in chapter three. In this introduction, I simply highlight a few gaps that supported the need for my study. Harm reduction first emerged in the 1960's among HCPs and activists that opposed the oppression of drug users and the movement gained significant traction during the 1980's among HIV/AIDS activists and injection drug users (Roe, 2005). As a guiding philosophy of care, harm reduction has come to be conceptualized as "meeting people where they are" with their substance use and not insisting that people stop using drugs (Kerber et al., 2020; Sue, 2021). Substance use refers to both legal (e.g., alcohol, caffeine,

cannabis, nicotine, tobacco), and illicit substances (e.g., cocaine, hallucinogenic drugs, methamphetamines, opiates,). Nicotine and alcohol cause significant morbidity and mortality (e.g., cancer, liver disease), but illicit substance use tends to be more stigmatized than legal substances (Shahid & Neufeld, 2024). A harm reduction approach acknowledges that substance use is not necessarily problematic (i.e., drug abuse, addiction) and policies often causes a large part of the harm of using substances (Cross, 2017). Therefore, some harm reduction advocates have reframed the overdose crisis as a drug policy crisis or housing crisis, because it shifts from victim blaming individuals for their behaviours and choices, which are constrained by Social Determinants of Health (SDH), towards blaming harmful policies for overdoses and deaths among people who use substances (Cross, 2017; Daniels et al., 2021; Hyshka et al., 2017). The colonial emergence of substance use policies and the ways in which these policies are rooted in systemic racism are poorly documented in the nursing literature, despite the impact of these policies on SDH, health equity, and anti-Indigenous discrimination and stereotypes.

Harm reduction is an inherently ethical approach for nursing; however, it faces considerable criticisms. A conservative backlash against harm reduction is growing, but there are also critiques from within the social world of harm reduction (Macevicius et al., 2024). Some researchers criticized that harm reduction philosophies and programs are overly medicalized, individualized, and depoliticized (Cross, 2017; Goodyear, 2021; Hyshka et al., 2017; Macevicius et al., 2024; Roe, 2005). Additionally, people have suggested that harm reduction programs and spaces tended to be predominantly White spaces and may not be welcoming to BIPOC staff and clients (Godkhindi et al., 2022). Research in rural and northern British Columbia (BC) found that Indigenous people face disparities in access to harm reduction due to racism, sociopolitical issues, and geography (Barker et al., 2025). Studies are lacking that explore how anti-Indigenous

racism and colonialism manifest in harm reduction. Based on the above literature, we have limited knowledge about what Indigenous people experiencing homelessness might need and want from harm reduction programs in urban Ontario (Godkhindi et al., 2022). These gaps must be explored in future studies with Indigenous people experiencing homelessness.

There is also a paucity of research that examined CHNs perspectives on their provision of community, street outreach, and/or harm reduction nursing care within urban Indigenous communities (Paradis-Gagné et al., 2020; Pauly, 2014). Based on homelessness point-in-time counts, nurses that work in harm reduction have the potential to encounter Indigenous people experiencing homelessness on a regular basis, and thus one could assume that Indigenous homelessness would be a salient issue for their practice. However, little is known about nurses' perspectives on the care they provide to Indigenous people experiencing homelessness, or nurses' awareness of issues relevant to Indigenous homelessness (e.g., Indigenous rights), and how they struggle against colonialism in their day-to-day work. Within nursing, the practices of CHNs and the ways in which they understand Indigenous homelessness, enact cultural safety, and their responses to the TRC Calls to Action are largely absent from the literature. My study focused on these gaps so that nurses' needs for training and support can be tailored to the practice area.

My study primarily focused on CHNs that worked in harm reduction. Harm reduction is an ideal practice area to explore nursing action against all forms of oppression because of their explicit mandate to serve marginalized communities. Therefore, I contend that harm reduction is also an ideal social world to explore anti-racism in community-based nursing. However, it is unclear from the literature whether or not CHNs' knowledge and awareness of discrimination related to substance use and homelessness results in greater understandings and actions against systemic racism and settler colonialism. To that end, I expanded from my theoretical explorations

and conducted a situational analysis (SA) with CHNs working in harm reduction where they serve urban communities with high rates of Indigenous homelessness.

Research Overview

Firstly, I situate my research within nursing obligations and progress towards meeting the TRC Calls to Action. Nurses have ethical obligations to uphold human rights and fight against health inequities (Canadian Nurses Association [CNA], 2017; International Council of Nurses [ICN], 2021). Ethical obligations to truth and reconciliation also suggest that nurses must uncover their complicity with settler colonial systems that uphold White supremacy and perpetuate Indigenous homelessness and health inequities (Symenuk et al., 2020). Although, these ethical obligations are not made explicit in nurses' code(s) of ethics (Tisdale & Symenuk, 2020), nursing organizations including the CNA have committed to uphold the TRC. However, progress towards meeting the TRC Calls to Action are painfully slow and none of the Calls to Action in health have been completed (Jewell & Mosby, 2023).

Specifically, Calls to Action #23 and #24 called for mandatory cultural competency training for practicing nurses and obliged nursing schools to address anti-Indigenous racism and the legacy of colonial violence in Canada through education on Indigenous health, human rights, the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) and Treaties (TRC, 2015). Current theoretical approaches to cultural competency are inadequate to guide nurses anti-oppressive work because they pay insufficient attention to racism (Curtis et al., 2019; Gustafson, 2005; Mulholland, 1995; Pon, 2009) and thus are also inadequate to meet the TRC Calls to Action. Cultural competency was not used as the theoretical framework for my study because of these limitations. Limitations of cultural competency were examined in this study and will be discussed at length in Chapter 5. Cultural safety is frequently cited in registered nurse

(RN) practice standards including by the College of Nurses of Ontario (CNO), but in some ways it has merged with cultural competency. My research draws on cultural safety, relational ethics, and critical feminist works as the theoretical underpinning of my study.

Theoretical Framework

Cultural safety was originally developed in the 1990's by Māori nurse Irihapeti Ramsden and was grounded in feminist and Indigenous relational ethics (Ramsden, 2002). However, more recent iterations of this concept have moved away from these critical Indigenous underpinnings (Hunter & Cook, 2020; Koptie, 2009; Ramsden, 2002). Relational ethics are essential to cultural safety (Bourque Bearskin, 2011). In my theoretical approach, I attempt to return to the roots of cultural safety by drawing on relational ethics and critical Indigenous theories and relational worldviews. My intentions are not to articulate a theory of Indigenous relational ethics for nursing, because as an outsider looking in, that is not my place. Rather, my intent is to highlight some implications of Indigenous ways of knowing for nursing practice and how Indigenous paradigms and worldviews can positively influence nursing ethics. Importantly, the person receiving nursing care ultimately determines whether care is culturally meaningful and safe or not (First Nations' Health Authority [FNHA], 2020). This shift in power towards the person receiving care is a critical element of cultural safety. However, this also creates some practical challenges for nurses to identify and build culturally safe practices without soliciting feedback from their patients/clients (Anderson et al., 2003). Soliciting feedback may be an opportunity for people to feel heard, but it could make some clients uncomfortable. People may be unable to provide honest feedback, particularly if they are socially compromised in some way (Curtis et al., 2019; Kelly & Chakanyuka, 2021; Pauly et al., 2016; Richardson & Reynolds, 2014).

Relational ethics is an umbrella term that includes many theories and perspectives. In this study, I draw on Indigenous theories of relational ethics and Kelly Oliver's feminist theory of ethics based on witnessing. I believe Oliver's unique perspective makes important contributions to nursing theory and ethical practice. In Oliver's (2001) book *Witnessing Beyond Recognition* she critically deconstructed notions of subjectivity, agency, and identity based on recognition, and articulated a theory of subjectivity based on witnessing. Oliver argued that theories based on struggles for mutual recognition are essentially antagonistic and that witnessing is an ethical approach for opening oneself unto otherness. She noted feminists, including herself, have sought theories of subjectivity that account for political agency, acknowledge social and political positionality of subjects, and open up the possibility of ethical relationships (Oliver, 2000, 2015). These are also key features that I seek in my own theoretical framework for this study.

Methodology

My chosen method Situational Analysis (SA) has a theoretical basis in social worlds and arenas theory. Developed by Adele Clarke, SA is an extension of Strauss and Charmaz constructivist grounded theory (GT). Clarke's goals when she developed SA included to push constructivist grounded theory more fully into feminist and post-structuralist terrain and to shed GT's more positivist roots (Clarke et al., 2016; Clarke et al., 2017). I primarily collected data through in-depth interviews with community health and harm reduction nurses that work with homeless populations. Extant discursive materials including mainstream media news articles and nursing websites also formed a secondary component of the analysis. SA is unique from GT in that it utilizes a series of mapping exercises as part of data analysis to explore the situation of interest and expose underlying elements and discourses that influence actions and social processes (Clarke et al., 2016; Clarke et al., 2017).

Within SA there is some key terminology that is important to parse out as it is also part of my research question. Firstly, Clarke et al. (2017) made the distinction between context that "clearly denotes that which surrounds something, but assuredly is not part of it" versus situations where all "entities in relation to each other are constitutive of each other" (p. 17). Furthermore, they argued that from a relational perspective there is no such thing as context. They identified key situational elements including political, institutional, sociocultural, symbolic, spatial, temporal, human and non-human elements, and popular and other discourses (Clarke et al., 2017). Arenas are the broader situations where multiple social worlds encounter and interact with each other, and therefore, are often sites of contested discourses and actions. Social worlds "generate shared perspectives that then form the basis for collective action, while individual and collective identities are constituted through commitments to and participation in social worlds and arenas" (Clarke & Star, 2008, p. 116). Social worlds can intersect, grow, and branch out to become arenas, for example, nursing consists of multiple diverse social worlds such as critical care or public health. Both healthcare and homelessness in Ontario more generally, would be considered arenas. Meanwhile community health and harm reduction nursing with homeless communities would be considered a social world. The philosophy of harm reduction is also a shared perspective that forms the basis of collective action among some people who use drugs and their co-conspirators against criminalization and other harmful drug policies.

Aims and Objectives

The aim of this study is to critically examine how settler colonialism is embedded in nursing and how this influences community nursing practices in the area of urban Indigenous homelessness. My research focused on community health and harm reduction nurses that primarily work with urban homeless communities and provide direct client care, including

outreach nurses, and nurses working in community health centers (CHC) and supportive housing and harm reduction programs. For the purpose of my study, I collectively refer to this group of nurses as CHNs but recognize that this term may also refer to nurses that work in other practice areas such as rural and remote nursing (e.g., outpost and health centers in Indigenous communities), which were not included in this study because it centered around *urban* Indigenous homelessness. One of the strengths of SA and part of my rationale for using this method was to provide an in-depth relational ecological overview of systems, structures, and circulating discourses impacting nurses' actions. Therefore, this thesis tacks back and forth between the niche of CHNs working in a medium sized city in Ontario and the broader situation of Ontario and Canada. SA doesn't necessarily result in a tightly bounded case study.

My research question was:

How do situational elements influence CHN's engagement with anti-colonial struggles within themselves, within their harm reduction social worlds, and more broadly within the socio-political arenas of healthcare and urban homelessness in Ontario?

My research objectives were to:

1) Describe CHNs' perceptions about Indigenous homelessness and their relationships and nursing practices with Indigenous persons living in homelessness.

2) Explore situations of urban Indigenous homelessness and community healthcare and examine how situational elements may influence CHN's anti-colonial struggles.

3) Identify anti-colonial beliefs and actions among CHNs and the ways in which CHNs perpetuate, maintain, or challenge settler colonialism and racism in healthcare.

4) Explore how theories of relational ethics may inform anti-oppressive nursing practices with urban Indigenous homeless communities.

Dissertation Overview

In the following chapters, I critically examine how settler colonialism is embedded in nursing and how this influences CHN practices in the area of Indigenous homelessness. Given the breadth of background information requisite to understanding the various elements of my research problem, I did not undertake a systematic review or exhaustive analysis of a narrowly defined area, nor do I offer one sole discussion chapter. Throughout various chapters in this thesis, I provide background and integrate discussions of research and theoretical literature as it relates to my findings. I do not include a dedicated background chapter, beyond what I provided previously in this introduction. Therefore, the next chapter moves straight into methodology.

Chapter two provides an overview of the critical philosophical methodology to my study and a description of SA method in detail. To begin, I reflect on my own positionality as a White settler and describe the importance of assuming a learner's stance. I provide an overview of key-concepts requisite to understanding racism including intersectionality. I parse out the basis of my theoretical framework, which I expand on throughout the following chapters as it applied to my analysis and findings. I chose not to dedicate a separate chapter to explaining my theoretical framework and preferred to weave theory throughout the entire dissertation. This approach allowed for a deeper connection and illustration between theory and its applications. Finally, I describe my methods in detail including ethical considerations, data collection, and analysis. I introduce three types of mapping, which are hallmarks of SA.

Chapter three marks the start of my situational analysis. I do not draw on interview data yet, but rather analyze extant discursive material (e.g., academic literature, news media articles, and historical documents). Substance use was the proverbial elephant in the room during my study. This chapter explores many intersections between criminalization of substance use,

Indigenous homelessness, and anti-Indigenous racism in healthcare and exposes the enormity of these issues. I argue systemic racism is a social process that manifests in racist policies and health disparities. I provide analysis of White supremacy and White racial behaviours that uphold systemic racism. I describe problems of colonialism, and the circulating discourses about Indigenous Peoples in nursing. I explore historical elements and situate anti-Indigenous racism in nursing history. I focus on circulating discourses about harm reduction and the racially coded language used in news media related to substance use and homelessness. Complex arenas surround CHNs social worlds. This chapter situated their anti-colonial struggles into the broader sociopolitical situations in Ontario and Canada more broadly.

Chapter four moves into research findings from CHNs interviews. I provide a relational ecological overview of situational elements that may influence CHNs anti-colonial struggles. I begin with describing the social worlds and arenas that interact with Indigenous homelessness and the sites of CHNs' nursing actions. Next, I describe my sample of CHN participants. Following these demographics, I present a map of situational elements and summary of the different types of elements (including regulatory and legal elements that are the focus of the next 2 chapters). I also present positional maps that reflect the various discursive positions taken or not taken (i.e., silences) in the interview data. Discourses were produced in the co-construction of interview data between myself as researcher and the participants. I explored CHNs discursive constructions of Indigenous homelessness and other actors/actants, and CHNs perspectives of key issues within their social worlds. Finally, I note the conceptual confusion that emerged surrounding cultural competency/safety and frameworks within the TRC Calls to Action.

Chapter five offers a fulsome discussion of cultural competency, and approaches of various nursing organizations towards the TRC Calls to Action. I provide background to the

history of cultural competency, including its roots in Leininger's theories. I compare and contrast cultural competency with cultural safety. As part of my analysis, I conducted website reviews of select national nursing associations and all of the provincial and territorial regulatory colleges to look for anti-oppression content. I found that cultural frameworks rather than anti-racism dominated practice expectations and entry level competencies. Additionally, there were few measures to hold RN membership accountable to TRC Calls to Action. Finally, I explore CHNs' knowledge gaps and conceptual confusion surrounding cultural competency versus cultural safety. CHNs also identified some of their own learning needs and importance of reflexivity.

In chapter six, I examine progress on the TRC Calls to Action in health. CHNs described barriers and progress within their workplaces. Leadership was one of the most prominent (dis)enablers to action. CHNs also described slow, but positive progress and promising practices within their organizations. CHNs noted their own knowledge gaps in relation to UNDRIP, Treaties, and the TRC Calls to Action; therefore, I describe some ways in which UNDRIP and Treaties relate to nursing practice. Healthcare and housing are human rights. UNDRIP clearly states that Indigenous Peoples have the right to access these basic human rights free from discrimination. Unfortunately, evidence indicates that these rights are frequently violated in Canada. High rates of Indigenous homelessness, health disparities, and stories of racism in healthcare are all clear evidence of violations of UNDRIP and human rights. Finally, I critically appraise and contrast three ethical codes relevant to nurses in Ontario, the CNO's Code of Conduct, the CNA's Code of Ethics, and The ICN's Code of Ethics. I argue that to make meaningful progress on the TRC Calls to Action that ethical codes for nurses should make explicit the connection between social justice and UNDRIP. Additionally, Indigenous relational ethics offer a pathway towards cultural safety and providing culturally meaningful care.

Chapter seven looked closely at ways CHNs upheld or challenged colonialism and racism. I identified two critical aspects of CHNs internal anti-colonial struggles: 1) seeing racism and 2) overcoming silence. Important anti-oppressive actions emerged into view. CHNs invested considerable time and effort into behind-the-scenes work (e.g., advocacy, systems navigation, care coordination), which was generally done for clients on their behalf rather than with them. I suggest that the concept of healing centered engagement may help move advocacy towards doing *with* rather than *for* people. Witnessing emerged as an important relational practice that has potential to improve CHNs capacity to see racism and act against it. Assuming a learner stance, suspending judgment, narrative elicitation, and shared decision making were also essential relational practices and I expand on these practices in relation to extant literature and theory.

Finally, chapter eight concludes this thesis. My study provides an in-depth relational ecological overview of situational elements that influenced CHNs anti-colonial struggles in harm reduction and identified important anti-oppressive practices. In this final chapter, I summarize my research findings and describe implications of my current study for nursing. I note potential limitations of my study. Some research implications are cursory, because CHNs' actions have not been explored from perspectives of people receiving care as a cultural safety approach demands. In future studies, nursing actions must be explored with Indigenous people with lived experience. Thus, my findings offer many possible directions for research. I conclude this chapter with some personal reflections on my learning about racism as a White settler. I hope that I can foster an open and honest dialogue about anti-Indigenous racism and settler colonialism in nursing.

Chapter Two: Methodology and Theoretical Underpinnings

> *I marvel over nurses who continue to practice in advanced settings, borrowing knowledge from various disciplines to expand their repertoire of understandings of multiple ways of knowing. Yet I question why Indigenous knowledge has been excluded from the development of nursing knowledge. Of particular concern for me now is how Indigenous knowledge can influence nursing practice and contribute to the advancement of nursing knowledge.*
>
> *Dr. Lisa Bourque Bearskin – Cree Métis Nursing Scholar (2014, p. 88)*

In this chapter, I describe the theoretical underpinnings of my study. I then discuss ethical considerations and specific details of my SA methods including data collection, data analysis, and situational mapping. My overall philosophical approach to my research is rooted in a critical paradigm. Related to the quote above about Indigenous knowledges, Bourque Bearskin (2014) also described the propensity among Western nurses to draw on writings of "dead white male philosophers" (p. 26) to form the basis of their theoretical frameworks. I agree that many nursing scholars draw heavily on theoretical works by White European men (e.g., Heidegger, Hegel, Foucault, Deleuze). Their theories may be useful for nursing, but at times these philosophers problematically used a universalizing tone, ignored the experiences of women and colonized peoples, and failed to acknowledge that the lens through which they saw the world was both White and male (Spivak, 1994). Therefore, nursing scholars must critically engage with a wide variety of theoretical works and explore how Indigenous knowledges can be meaningfully included into the nursing discipline (Bourque Bearskin, 2014; Bourque Bearskin et al., 2020).

I draw on critical theoretical approaches in my study to explore an ethical stance for CHNs grounded in Indigenous and feminist relational ethics. I attempt to include Indigenous perspectives within my theoretical approach, albeit cautiously, and with due concern for issues of cultural misappropriation. I introduced Indigenous relational worldviews in the previous chapter, and I go into more detail on Indigenous relational ethics in subsequent chapters in relation to

cultural safety and the TRC Calls to Action. In this chapter, I articulate my critical feminist worldview, which is informed by my own lived experiences, many conversations with friends, colleagues, mentors, and people I have cared for in my nursing practice over the years, as well as my readings of a diverse array of literature, all of which greatly expanded my understandings of the nursing discipline, critical social theories, racism, oppression, and Canadian histories of colonialism and Indigenous dispossession of territories and cultures.

Positionality and Reflexivity

To begin, I situate myself as a White nurse of settler colonial descent. My hometown located just east of the Rocky Mountains, straddles Treaty Six and Treaty Seven territories, along the banks of the Red Deer River and James River. I also have strong ties to the Qu'Appelle Valley and Lake Katepwa. The waterways where I played were historically traversed by many Métis and First Nations Peoples. Later, I lived in Yellowknife, on traditional Dene territory and worked as a nurse at Stanton Territorial Hospital. There, I cared for Inuit, Métis, and First Nations Peoples that often traveled long distances to access healthcare, which is inequitably centralized into medical travel hubs by the federal and territorial governments of Canada, the Northwest Territories, and Nunavut. I now live on the traditional and unceded territory of the Algonquin Anishinaabeg. During my doctoral studies, I also worked as a community health and harm reduction nurse to provide nursing outreach to persons with lived/living experiences of homelessness in Canada's capital city. Many people in Ottawa's homeless community identify as Indigenous from different nations and lands all across Turtle Island. This diversity in the homeless community is evidence of displacement and land theft. However, Indigenous diversity and shared resilience can also be a beautiful strength in the face of colonialism.

People (whether they identify as Indigenous or not) that I engaged with in my nursing practices have complex physical health needs, and many struggle with substance-use, complex trauma, and mental illness. I have experienced my own struggles with mental illness and stigma, but I have done so from the safety of my home. I do not have lived experiences of homelessness or racism. Like many Canadians, I consume legalized substances; however, I have never experienced the criminalization and stigma of persons who use illegal substances and/or are labeled an addict and/or are forced to use legal or illegal substances in places where they endure public scorn. My lack of lived experiences limits how I see and understand the world around me and the oppressions that others face. I recognize that when it comes to healthcare I am still learning (and always will be) and people with lived experiences are the experts. Potential pitfalls for me, a White settler researcher, to examine and represent nurses' perspectives through research includes risks of amplifying privileged voices and undermining Indigenous perspectives and agency. These concerns must not be underestimated and these risks demand vigilance in methodological approaches, data analysis, and representation of findings. As a White settler nurse this research project demanded that I assume a learner's stance and critically question my own biases and complicity with colonial healthcare systems and political structures in Canada. I will always be a learner and never an expert on racism and colonialism.

I use the term anti-colonialism as a specific form of anti-oppression work that privileges the needs of Indigenous Peoples, addresses anti-Indigenous racism and settler colonial violence and incorporates intersectionality. I argue that unraveling settler colonialism within ourselves, and within the discipline of nursing, is an important component of engaging in anti-colonial struggles. I use the word struggle to describe the difficult work of reflecting on our complicity within systems of oppression based on race, class, gender, (dis)ability etc., and fighting to

dismantle these systems. To orient nursing practice towards anti-oppression nurses must first identify, and then remedy the ways in which they reproduce settler colonial harms in healthcare (Al-Chami et al., 2024; Nath & Allen, 2022).

Importantly, my anti-colonial project requires that I commit to critical reflexivity and a praxis-oriented approach. Critical reflexivity requires self-interrogation of one's positionality in the world and the ways in which our subject position limits our knowledge and understanding of the social realities of others (Ng et al., 2019). The focus of reflexivity is on discursive worlds and interrelatedness of social norms and power relations and it aims to develop agency and influence systems change (Ng et al., 2019). The concept of critical reflexivity, which is congruent with the theoretical underpinnings of this study, is theoretically distinct from critical reflection. The two concepts may be complementary and critical reflection is commonly used in nursing education and originated in the works of Aristotle, Habermas and Freire (Ng et al., 2019). However, we should not simply assume that because the English translation of Freire's work used the term reflection that this is congruent with the meaning and intent in his original writings. For example, Freire refused to translate *Conscientização* from Portuguese not simply because English words could not accurately capture its meaning, but also to reclaim oppressed voices. He argued that words such as *Conscientização* that seek to unveil the mechanisms of oppression are sequestered or distorted by the dominant majority (Macedo, 2021). A recent example of this distortion is the misappropriation of the anti-oppressive term *Woke* by the conservative right as a pejorative.

To conceptualize how nurses might struggle against all forms of oppression, I draw on Freire's (1971) concept of praxis—A constant tacking back and forth between critical reflection and deliberate action for the purpose of transformation. Furthermore, transformative action depends on the nurse's ability to interrogate oneself to understand how their normative and

colonial assumptions impact development of their own knowledge, nursing skills, and provision of care. Freire's (1971) groundbreaking work, The Pedagogy of the Oppressed, focused more on liberatory education among the oppressed. He also noted the need for people with privilege (i.e. the oppressor class) to join together with the oppressed in their struggles for freedom; however,

> as they cease to be exploiters or indifferent spectators… and move to the side of the exploited, they almost always bring with them the marks of their origin… which include a lack of confidence in the people's ability to think, to want, and to know… [They] constantly run the risk of falling into a type of generosity as malefic as that of the oppressors. The generosity of the oppressors is nourished by an unjust order, which must be maintained in order to justify their generosity. Our converts, on the other hand, truly desire to transform the unjust order; but because of their background they believe that they must be the executors of the transformation. (Freire, 1971, p. 60)

Freire (1971) goes on to suggest that problems described above, which are consistent with problems of White benevolence, saviorism and paternalistic racism, can only be overcome through *mutual* trust, dialogue, and humility. He described that conversion to the side of the oppressed is a "radical" endeavor and that one "must re-examine themselves constantly" (p.60).

I believe that all people, regardless of race, can and should engage in anti-colonial struggles, but I reserve the term anti-colonial resistance to describe the work that Indigenous Peoples are doing to fight against colonial oppression and decolonize their lands and lifeways. Similarly, it is important to distinguish between elements of decolonization (e.g., relinquishing control over Indigenous territories, ending systemic racism, addressing harmful White racial behaviours, dismantling colonial systems and structures) that are the responsibilities of non-Indigenous people and the work of Indigenization including rebuilding and revitalizing

Indigenous knowledges, governance systems and wellness practices (Bourque Bearskin, 2023; Came & Griffith, 2018; Came & Humphries, 2020; Kelly, 2024). Due to risks of settler nurses' anti-oppression work slipping into White saviorism and/or White benevolence (i.e., paternalistic racism), the importance of my next point cannot be understated—*Indigenization must be led by Indigenous Peoples.* Non-Indigenous people must cultivate authentic partnerships, stand in solidarity with Indigenous Nations and amplify Indigenous voices and concerns. That said, the scope of work required to achieve health equity and end Indigenous homelessness is immense and Indigenous Peoples should not be expected to do the heavy lifting of exposing the truth of settler colonial violence. "It is not the work of Indigenous Peoples to decolonize our institutional systems and structures, we are only the litmus paper" (Bourque Bearskin, 2023, p. 4). Nor should institutions expect Indigenous nurses to be the sole providers of cultural safety training and/or to be the ones to teach students about racism and Indigenous rights (Came & Griffith, 2018; Kelly, 2024). This epistemic exploitation of Indigenous nurses hinders their own scholarship and allows institutions to shirk their responsibilities towards truth and reconciliation when Indigenous people are unavailable to do this work (Bourque Bearskin, 2023). When work is conducted by non-Indigenous persons, the power of Indigenous groups to lead, consult, evaluate, and veto proposed policy changes, programs, and projects is critical.

Nursing care at a minimum should make people feel safe, but ultimately the goals of care should be to support healing and human flourishing. Consideration of Indigenous knowledges and ways of knowing may contribute to more culturally meaningful care moving beyond the laudable goal of making people feel safe (e.g., cultural safety, trauma informed care), and move towards building nursing relationships that promote equity, community healing, and human flourishing (Bourque Bearskin, 2011, 2014; Bourque Bearskin et al., 2020; Harry, 2014). During

this study it was critical that I assume a *learner's stance*. A learner's stance requires cultural humility, striving toward cultural safety, reflecting on our personal biases and behaviours, taking time to listen to Indigenous Peoples and read Indigenous works, learning about the unique histories, knowledges and lifeways of First Nations, Inuit, and Métis Peoples, seeking input, and accepting critical feedback from others (Gebhard et al., 2022; Latulippe, 2015). We (as nurses) need to *learn* how to build trusting relationships with Indigenous communities to provide culturally meaningful and compassionate care. Importantly, we need to *learn* about settler colonialism as a starting point for change. I fully commit to this learning and challenges that may entail as I engage in nursing research. I acknowledge that I have much to *learn* about my own complicity with colonialism and my responsibilities towards reconciliation.

Theoretical Assumptions About Racism and Importance of Intersectionality

Race is a social construction with no biological basis (Sane, 2001). Racial categories are fluid, complex, and contested. Processes of categorizing people into racial hierarchies is rooted in an ideology of White supremacy, whereby Western Europeans identified themselves as White and as superior to others (James, 2001; Kendi, 2019). Indigenous is an internationally recognized term with legal implications for rights to territory and self-determination, but it is also used as a racial category. The terms settler and Indigenous importantly describes people's relationships to territory and emplaces groups of people in relation to colonial oppression. White may be one of the most confusing racial categories, as who is considered White and who is not has shifted over time (James, 2001). Whiteness is an invisible (i.e., normalized and erased by White people) standpoint through which White people view the world (Frankenberg, 1988). Therefore, White is a worldview more so than a collection of physical features (e.g., skin color, hair color/texture). Although, people must also appear to be of European decent to be regarded as White.

There are many nuanced and sometimes conflicting descriptions of racism. Some ideas are controversial and may contribute to the current backlash against critical race theories (CRT) and education, these include: the notion that all White people are racist and only White people are racist; the notion that White privilege eclipses all other forms of privilege and oppression (i.e., race is the most important axis of oppression; therefore, White people that are oppressed by gender, class, ability etc., still experience greater privileges than BIPOC[2] Peoples); the notion that any claim to uphold the ideals of equality and meritocracy are inherently racist (e.g., color blind racism and false claims of reverse racism); the notion that systemic racism exists and it means that all White people in the system are racist. Indeed, when White people are presented with definitions of racisms and racists that incorporate the above assumptions then they often become overly defensive. Alternately, White people might make performative declarations about their privilege and deem themselves to be inherently racist as a form of virtue signaling (e.g., that uncritically accepting their Whiteness and racial faults makes them more enlightened than those that are too ignorant, hateful, or immoral to concede that they are part of the problem). I suggest that nuance in any discussion of racism is critical and sweeping generalizations are problematic.

A definition of racism does not exist that can easily categorize all individual incidents of prejudice, discrimination, and/or systemic oppressions as racism or not. Discrimination is action based on prejudice (Kendi, 2019), which can be rooted in multiple human behaviours, characteristics, and identities (e.g., race, gender, sexual orientation, substance use, (dis)ability,

---

[2] People are often labeled as Black, Indigenous and other Persons of Color (BIPOC) or White; a binary that serves to delineate those who experience racial oppression from those who do not. This collapses considerable cultural variation and may limit our understandings of how racisms manifest in unique situations. This binary may at times problematically re-center whiteness as the normalized and often unnamed standard, perpetuate cultural essentialism and othering. I use the term BIPOC with hesitation. It is a useful, but imperfect term.

health/illness). The importance of intersectionality cannot be understated, and this lens helps to overcome some of the critiques described above. Intersectionality theory, which is increasingly being adopted by nurse researchers, provides an ideal lens to explore intersections between multiple forms of oppression (Hankivsky & Christoffersen, 2008; Van Herk et al., 2011). Oppression goes beyond what is visible. A person may publicly and/or privately deny or conceal membership in an oppressed group, for example, persons with mental illness or HIV may hide their diagnosis from others. Despite this hidden identity, oppression may be perceived by the individual based on stigma, shame, fear of being outed, or be enacted in contexts where an individual is unable to conceal their membership with the oppressed group (Mullaly, 2001).

Systems of oppression are not discrete categories, they are interlocking, dynamic, and contextually bound, this is the essence of the term intersectionality first articulated by Black feminist and legal scholar Kimberlé W. Crenshaw (1991). Although, intersectionality was credited to Crenshaw, scholars from many disciplines prior to 1991 and since have used various combinations of feminism with CRT, Marxism, critical Indigenous theories, anti-colonialism, and postcolonialism to explore oppression (Cooper, 1892/1988; Davis, 1983; Green, 2017; hooks, 1981, 2000; Loomba, 2015; Spivak, 1994). Sojourner Truth's (2020) famous 1851 speech *I am a woman's rights* was a trailblazing example of intersectionality, where she argued for White feminists to include Black civil rights and emancipation from slavery into their aims. These scholars and activists arguably applied an intersectional lens to their work. CRT at times makes sweeping generalizations about race and racism based on anti-Black racism and slavery in the United States (US) in ways that minimize the centrality of colonialism in current systems and structures and may actually contribute to the theoretical erasure of Indigenous Peoples (Bodnaresko, 2024; Brayboy, 2005; Dua et al., 2005; Lawrence & Dua, 2005). These critiques

highlight why studies of anti-Indigenous racism in Canada must not rely solely on CRT that emerged out of the US. Therefore, I also draw on Indigenous scholars and their studies of settler colonialism and the anti-Indigenous policies of the Canadian State in particular (Coburn, 2009; Coulthard, 2007; Green, 2017; Teillet, 2019).

Critical Philosophical Approach

The received view of science (i.e., logical positivism) suggests that researchers can be objective, neutral, and detached—an unbiased observer of *others'* experiences in one *real* world (Rigney, 1999; Smith, 2021). This is also the paradigm of traditional bioethics, which assumes principles can be objectively, rationally, and universally applied. The philosophical underpinning of my study's relational ethics framework and SA methods are based in a critical paradigm. According to Guba and Lincoln (1994), the ontology or nature of reality in a critical paradigm is "historical realism, which assumes an apprehendable reality consisting of historically situated structures that are, in absence of insight, as limiting and confining as if they were real" (p 111). Knowledge is socially constructed, and historically situated. For example, the perception that the earth was flat limited the development of scientific knowledge and social structures as if the world really was flat. In today's global world, the economy, war, aeronautical engineering, and infectious diseases (e.g., COVID 19 pandemic) have evolved, in part, because of human knowledge that the world is round. I perceive historical realism is applicable to both the physical sciences (e.g., biology, physics, chemistry) and the social sciences (e.g., anthropology, sociology), this makes it relevant to health sciences, which is a blend of both.

The axiology of a critical paradigm assumes that knowledge, and the production of knowledge, is value-laden, and is influenced and controlled by hegemonic power structures (Guba & Lincoln, 1994). Throughout history, traditional Western research approaches have

intentionally contributed to colonial and patriarchal oppression, which demonstrates the lack of neutrality in research (Battiste, 2016; Chilisa, 2012; Flaherty, 1995; Rigney, 1999; Smith, 2021). The epistemology and ontology of a critical paradigm are interconnected, with the values of researchers, participants, and others influencing research processes and outcomes. This highlights the interactive nature of inquiry within the epistemology, which necessitates the inclusion of dialogue and praxis in the methodology of critical research (Freire, 1971; Guba & Lincoln, 1994; Smith, 2021). A praxis oriented approach is also promoted within the nursing discipline, and attention to power imbalances is fundamental to nursing research oriented towards health equity (Browne et al., 2011). Critical research is intended to embrace emancipatory ideals and to bring about social transformation (Guba & Lincoln, 1994).

Browne and Reimer-Kirkham (2014) described a turn in critical nursing perspectives based on Rogoff's feminist theory. A turn that started from criticism, which illuminated oppressions and allocated blame, to critique which "examined underlying assumptions" toward *criticality* that builds on the former, but emphasizes a "self-reflexive, praxis-oriented approach" (Browne & Reimer-Kirkham, 2014, p. 25). Consistent with *criticality*, I reject the rigid dichotomy of insiders and outsiders (Rogoff, 2003; Rogoff, 2006). Individuals are not outside the realm of human suffering, and one cannot proclaim to be an objective observer of it.

> In 'criticality' we have that double occupation in which we are both fully armed with the knowledges of critique, able to analyze and unveil while at the same time sharing and living out the very conditions which we are able to see through. As such we live out a duality that requires at the same time both an analytical mode and a demand to produce new subjectivities that acknowledge that we are what Hannah Arendt has termed 'fellow sufferers' of the very conditions we are critically examining. (Rogoff, 2003, para 17)

Roseneil (2012) argued Rogoff's notion of *criticality* does not naively suggest we possess the ability to unveil. Instead, she emphasized because of our location "in the conditions that we seek to examine, we must nonetheless struggle for, and towards, new ways of knowing and being" and alternate subjectivities (Roseneil, 2012, p. 21). This brings us to an important point about nurse researchers examining our own complicity in systemic racism and settler colonial violence. Realistically, it may be difficult to unveil or even see through the ways in which we perpetuate racial harm. Examining our own complicity demands critical reflexivity and vigilance in our methodological and theoretical approach. Furthermore, we cannot separate complicity from the broader sociopolitical situation that oppresses entire communities and subsets of the Canadian population (e.g., Indigenous women, Two Spirit people). Nurses perpetuate suffering when we remain silent about the politics that produce suffering (Georges, 2004), which underscores the importance of incorporating critical feminist and Indigenous perspectives that acknowledge the ways in which oppression and power are fundamentally relational.

My rejection of insider and outsider perspectives does not suggest that nurses' experiences with suffering are the same as the people we care for. Clearly, persons living through violence and trauma (e.g., from Indian Residential Schools or homelessness) experience human suffering beyond the imagination of most nurses unless they have also personally lived through it. But, as we engage in care with people, we are witness to their suffering and always located within it. "After the cultural turn, there is epistemologically no standpoint—feminist or otherwise—that is outside… that is above the social and cultural relations that are the object of our attention" (Roseneil, 2012, p. 21). Questioning claims of objectivity is common among many feminist approaches to research (i.e., to question and typically reject scientific claims that to be objective observers from the outside looking in is desirable or possible). Ermine (2007) also

commented on diverse viewpoints and the impossibility of objectivity.

> In its finest form, the notion of an agreement to interact must always be preceded by the affirmation of human diversity… Since there is no God's eye view to be claimed by any society of people, the idea of the ethical space, produced by contrasting perspectives of the world, entertains the notion of a meeting place, or initial thinking about a neutral zone between entities or cultures. The space offers a venue to step out of our allegiances, to detach from the cages of our mental worlds and assume a position where human-to-human dialogue can occur. (Ermine, 2007, p.202)

Ermine clearly highlighted the need for an ethical approach where dialogue and engagement with others different from ourselves can occur, which is fundamentally relational. This ethical space that Ermine described does not require disembodied objectivity to detach from our worldviews, but rather an understanding that our perspectives are always partial, embodied, and uncertain—we cannot fully know ourselves or others. Ideally, Oliver's theory of subjectivity based on an ethics of witnessing will provide an analytic frame to examine and produce 'new subjectivities' that Rogoff suggested that we need.

Theoretical Approaches to Relational Ethics and Cultural Safety

Critical social and feminist theorists such as Kelly Oliver and Judith Butler have specifically explored subjectivity, recognition, and relational power. I argue that their work is important to expand understandings of relational ethics and cultural safety. I did not locate examples where Oliver's work has not been applied to deconstruct nursing practices and Butler's work is not frequently used in nursing. Oliver (2015) and Butler's (2019, 2016) theories may allow us to deconstruct and build upon some of the frequently cited definitions of cultural safety and this is a novel application of their theories.

Deconstructing Cultural Safety

Culturally safe care is frequently defined by what it is not or the absence of harmful nursing behaviours, i.e., culturally unsafe care is any behaviours or "actions which diminish, demean or disempower the cultural identity and well-being of an individual" (Anderson et al., 2003, p. 198). Cultural safety emphasizes redressing power imbalances between nurses and persons seeking care (Dekker, 2016; Ramsden, 2002; Richardson et al., 2017). Understandings of power and how one's cultural identity comes to be disempowered requires further theoretical analysis. Unfortunately, definitions revolving around the absence of negative behaviours does not provide clear understandings of the kinds of actions one should strive towards. In addition to the "3 Ds" of culturally unsafe care (diminish, demean, and disempower), Wood and Schwass (1993) also suggested "3 Rs" of culturally safe care that included recognition, respect, and rights. Although the 3Ds and 3Rs provides a basic description of culturally safe and unsafe care, I suggest that notions of cultural identity and how they come to be recognized and respected, or diminished and demeaned, requires considerable theoretical unpacking. Furthermore, I suggest that behaviours that diminish or demean another's identity clearly illustrate relational harms, particularly as identities are formed in relation to others. However, to move beyond an absence of culturally unsafe care and towards care that promotes relational healing we need to consider whether recognition and respect for cultural identities and upholding individual rights (i.e., the 3 Rs) are adequate to redress power imbalances and remediate past harms.

A focus on healing requires us to consider how to *restore* positive identities and a sense of agency among those that have experienced harm to their cultural identities, including from racism and other forms of oppression, negative stereotypes, internalized stigma, and feelings of powerlessness (Ginwright, 2016, 2018). Additionally, cultural recognition is unlikely to

transform unequal power relations (Coulthard, 2007; Oliver, 2015), and may be inadequate to bring about aspects of cultural safety that seek to redress power imbalances in clinical practice. Furthermore, attention to power relations among individuals is relevant to nursing care, but it will not ameliorate Indigenous health inequities rooted in systemic racism and colonialism. CRT, anti-colonialism and critical Indigenous theories were also used as a lens in this study to explore systemic racism and to deconstruct normalized White racial behaviours that uphold White supremacist systems, which is discussed in the next chapter. I now turn to Oliver's theory of witnessing and critiques of recognition, which may help us explore some of the limitations of the 3Ds and 3Rs of cultural safety described above.

Subjectivity and the Structure of Witnessing

I begin with an overview of Oliver's theoretical stance on subjectivity based on the notion of witnessing. Consistent with other theories of subjectivity (e.g., Butler), Oliver described that subjectivity is always a dialogical intersubjectivity, i.e., identity and the self-conscious form in relation to others. Theories of identity based on recognition are implicit in most contemporary social theory, and specifically, agreement exists that we come to recognize ourselves through the recognition of others (Oliver, 2000). However, Oliver argued that the structure of subjectivity is fundamentally about address and response, not recognition. Subjectivity is an individual's sense of oneself (e.g., 'I am') and one's perceived agency (e.g., 'I can or I cannot'). Subjectivity is differentiated from subject position, which is an individual's relational position within society, and within a historical time and place (Oliver, 2003). Individual interactions necessarily include addressing others and responding to others, otherwise it would not be an interaction. Address and response may be simply a cry or whimper; moreover, it may be solely embodied (Oliver, 2015).

The self is constructed through individual interactions that are situated within a specific sociopolitical situation, which determines one's subject position or positionality. A subject's sense of agency is constrained or enhanced by both their subject position and previous interactions with others. At times, social circumstances seem to leave people powerless to make choices and relegates agency into the realm of non-existent. However, Oliver argued that the "contradictions and inconsistencies in historical and social circumstances guarantee that we are never completely determined by our subject position. It is possible to develop a sense of agency in spite of, or in resistance to, an oppressive social situation" (Oliver, 2004, p. 82). Agency then depends on whether the subject perceives that they have the possibility of address and response with others. The presence of an addressable other (i.e., witness) sustains psychic life. Meanwhile, the denial of any possibility for address and response undermines or annihilates subjectivity (Butler, 2009; Oliver, 2000, 2001). Oliver described the structure of address and response as witnessing, because this is also the structure that makes testimony possible. She calls on the tension between various dictionary definitions of the verb witness (e.g., to bear witness, to testify, to be present, or to see with one's own eyes). In particular, she focused on the productive tension between "*eyewitness* testimony based on firsthand knowledge, on the one hand, and *bearing witness* to something beyond recognition that can't be seen, on the other, [as] the heart of subjectivity" (Oliver, 2015, p. 483).

Furthermore, this dual meaning allows for an accounting of subjectivity and subject position. Eyewitnesses are always located in a particular time and place, because they were physically there to see, hear, smell, taste and/or touch. Oliver draws on the notion of eyewitness to articulate subject position in relation to historical and sociopolitical elements. She explained that subject position and subjectivity relate to politics and ethics respectively.

> Subject positions, although mobile, are constituted in our social interactions and our positions within our culture and context. They are determined by history and circumstance. Subject positions are our relations to the finite world of human history and relations—what we might call politics. Subjectivity, on the other hand, is experienced as the sense of agency and response-ability that are constituted in the infinite encounter with otherness, which is fundamentally ethical. (Oliver, 2015, p. 483)

Oliver uses response-ability as a play on words that reflects at once our ability to respond, and also our responsibility or ethical obligation to respond to others. Theoretically, the structure of witnessing allows for analysis at the juncture between the intersubjectivity of the nurse-person relationship and the subject positions of both settler nurses and Indigenous persons seeking care, which is critical for redressing power imbalances. Redressing power imbalances are also fundamental to cultural safety and my theoretical framework.

Inner Witness

The concept of the inner witness can explain both how subjectivity can be destroyed and how it can be restored. Therefore, the inner witness has implications for redressing culturally unsafe care that diminishes, demeans, and disempowers the cultural identity of another. Oliver takes the concept of an inner witness from Dori Laub, a psychoanalyst who worked extensively with holocaust survivors and is a holocaust survivor himself. Based on his work with survivors Laub argued that an internal witness or addressable other is required for psychic survival and extreme oppression/violence annihilates the inner witness and destroys subjectivity (Felman & Laub, 1992). Subjectivity can be restored only in the presence of an addressable other (i.e., witness). Thinking or dialogue with the self emerges through dialogue with others. Oliver explains that through our relationships and interactions with others “we develop a sense of an

internal witness, to whom we address our lives. Without this inner witness, we lose the ability to make sense of our lives, to articulate our experiences, and to act as agents in the world" (2003, p. 139). The inner witness highlights that cultural safety requires solid understandings of relational nursing practices to *restore* agency and *repair* identities harmed by racism and oppression. Therefore, cultural safety must not simply be defined by the absence of unethical behaviours (i.e., to not diminish, demean or disempower cultural identities of others).

Felman and Laub (1992) described the impossibility of witnessing from inside the holocaust; which one could certainly argue applies to the impossibility for Indigenous children to bear witness from inside Indian Residential Schools. The Holocaust and concentration camps

> extinguished philosophically the very possibility of address, the possibility of appealing or of turning to another. But when one cannot turn to a "you" one cannot say "thou" even to oneself. The Holocaust created in this way a world in which one could not bear witness to oneself… This loss of the capacity to be witness to oneself and thus to witness from the inside is perhaps the true meaning of annihilation, for when one's history is abolished, one's identity ceases to exist as well. (Felman & Laub, 1992, p. 82)

Oliver argued further that although victims of extreme oppression and dehumanization are also eyewitness to their situation, they are often "cognitively and perceptually destroyed as witnesses because…as objects and the inhuman they are unable to speak... To speak, to witness to their dehumanization is to repeat it by telling the world that they were reduced to worthless objects" (Oliver, 2000, pp. 40-41). In essence this functions to silence victims of oppression.

Tainted Witness and Testimonial Networks

Gilmore's (2017) intersectional analysis of tainted witnesses and testimonial networks are also relevant to my theoretical framework and analysis of circulating discourses. Gilmore explored in-depth how women in general, and racialized women in particular, become tainted witnesses in the stories they tell about their own lives, and the ways in which their testimonies travel through time and place in search of an adequate witness. She conceptualized "testimonial networks as circulatory systems that connect the discourses and sites through and across which person and testimony flow" (Gilmore, 2017, p. 3), and that people also "put forward personal accounts of suffering and those who encounter them form a transactional dynamic of testimony" (Gilmore, 2017, p.5). Therefore, in the context of nursing we might consider the testimonial network to include the nurse-person relationship and eliciting of narrative accounts of trauma, illness and pain, or personal suffering. The testimonial network would also include conversations among other HCPs, giving and receiving report, and documentation in medical records.

The advent of electronic medical records (EMRs) expands the reach of the testimonial network across place and time, because people can easily retrieve and view HCPs notes and may make judgments about people's documented behaviours, and without actually being eyewitness to the situation make moral judgments about their real or imagined suffering. Gilmore argued that "testimony moves, but judgment sticks" (2017, p.5); moreover, "attacks on her credibility will draw from a deep reservoir of bias that connects gender and race to status across popular culture and informal spaces as well as institutions" (Gilmore, 2017, p. 5). In this way people are not intrinsically a tainted witness, but rather, they become one as testimonials to their lived experiences and embodied suffering move and encounter judgments (Gilmore, 2017). In health care, some people may be more likely to become a tainted witness, for example, women and

BIPOC peoples in general are more likely to be disbelieved about their pain (Thurston et al., 2023). However, some people, regardless of race or gender, may attract particularly sticky moral judgments when they are marginalized by virtue of their constrained life choices or social positioning, such as people experiencing homelessness and people engaged in street involved behaviours. Gilmore suggested that human harms raise ethical questions about citizenship and

> what it means to be a person… to have a body, to act and be acted on by others, to know oneself as vulnerable and to experience oneself as beyond the reach of judgment, and to have such knowledge extend over time until it becomes both personality and social positioning. (Gilmore, 2017, p. 21)

For example, wealthy White males tend to benefit from excesses in credibility in healthcare and in the courts. Their stories are believed when others are not. This credibility excess extends to people who do harm to gendered and racialized others (Gilmore, 2017).

Limitations of Recognition

Drawing on Oliver's line of argument, I suggest that a theory of intersubjectivity based on witnessing rather than recognition is a more ethical and productive starting point for both truth and reconciliation in nursing, and compassionate relationships between nurses and Indigenous persons living with homelessness. Oliver challenged the notion that social struggles are solely struggles for recognition. Based on testimonial research, she argued that victims of oppression, violence, slavery, and torture are "not merely seeking visibility and recognition, but they are also seeking witnesses to horrors beyond recognition. The demand for recognition… is transformed by the accompanying demands for retribution and compassion" (Oliver, 2004, p. 79). Despite the demand for recognition by oppressed peoples, Oliver (2015) draws considerable attention in her work to the limitations of ethical theories that rest almost exclusively with

recognition. Firstly, she argued that it is critical to consider recognition in relation to subject positions and sociopolitical context, which she suggested are neglected by key theories of recognition (e.g., Hegel's Phenomenology of Spirit). Secondly, "the concept of recognition suggests a moment rather than a process. The culminating moment… is mutual recognition… and even the ideal of mutual recognition becomes suspect unless we acknowledge the impossibility of ever achieving it" (Oliver, 2015, p. 477). Further, the link between recognition and cognition are problematic. Either you have recognition or you don't, and it all depends on an "Aha" moment of understanding, a cognition (Oliver, 2015).

Political recognition and other kinds of recognition that are bound up with cognition, neglect the imaginative and affective dimensions of ethical life. Ethically we need to reach beyond the limits of our cognition, and extend compassion even if we don't understand others (Oliver, 2001). We need to struggle for new ways of being in relation to others, which requires a more radical intersubjectivity than recognition allows. Thirdly, while admirable, mutual recognition is virtually unattainable. In reality recognition is demanded by the oppressed and conferred by the oppressors—It is dispersed along an axis of power. Recognition thereby actually maintains hierarchies of power and does not help us overcome domination. Even if the struggle for recognition is won the power structure remains unchanged (Oliver, 2015).

Oliver (2001) argued further by drawing from Frantz Fanon, that oppression creates the need for people to demand recognition; therefore, recognition is a symptom of the 'pathology of oppression' rather than the cure. This pathology is an internalization of inferiority among the oppressed and a sense of lacking something that their oppressors have or can give them. "(T)he injustices of oppression create the need for justice. More than this, the pathology of oppression creates the need in the oppressed to be recognized by their oppressors, the very people most

likely not to recognize them" (Oliver, 2004, p. 79). Withholding recognition maintains privilege and power. Therefore, if oppressors are willing to confer recognition one would question why, was it given unconditionally? Arguably, even the ethical ideal of mutual recognition could be conceived as part of an exchange that commodifies recognition (Oliver, 2015).

Next, Oliver (2015) turned her attention toward feminist theorists (e.g., Butler, Kristeva) who argued that dependence and vulnerability should ground politics and ethics. The argument in favor of an ethics of vulnerability suggested that recognition of mutual vulnerability would open an ethical space to respond to the "cry of the human" or the other (Oliver, 2015). Mutual vulnerability is the notion that we can both wound and be wounded and the cry is seen as symbolic of human vulnerability. The basis of this argument suggested that oppressors literally can *hear* the cry of the other; however, the oppressors do not recognize the cry of the other as that of another human being. Similarly, the oppressors *see* the other, but they are *seen as* less than human, (i.e., racism equals a lack of mutual recognition). In other words, recognition of vulnerability would equal recognition of humanity (Oliver, 2015).

Oliver suggested that the notion of mutual vulnerability as a basis for an ethical subjectivity is flawed because the recognition of vulnerability does not necessarily lead to human compassion. Indeed, recognition of vulnerability is a prerequisite for violence. Vulnerability of others is exploited in oppression, interrogation/torture, slavery, and colonialism.

> But, it is also the case that in these violent situations, it can be the *recognition* of vulnerability, and even the *recognition* of humanity, that enables the most brutal violence… In an important sense, drawing on the rhetoric of animality or inanimate objects when referring to other human beings assumes recognition of their humanity in the very gesture of denying it. (Oliver, 2015, p. 479, emphasis in original)

Being human is also not a prerequisite for ethical responses from humans. People can, and often do, respond to the vulnerability of other than human life (e.g., pets, wildlife) with compassion. The notion of *mutual* vulnerability risks ignoring power differentials that some people are made more vulnerable than others because of their subject position (e.g., social or political oppression). Vulnerability is not equally distributed among everyone in society (Butler, 2016; Oliver, 2015).

Oliver argued that an ethical redress of the suffering of others caused by our own privilege "requires more than cognition or even imagination. It requires *pathos* beyond recognition… an ethics of impossible responsibilities for what we do not and cannot recognize" (2015, p. 475). Openness to otherness requires "vigilance in listening to the silences in which we are implicated and through which we are responsible to each other" (Oliver, 2000, p. 39). Anti-colonial struggles among nurses requires that they bear witness to pain and suffering that most nurses cannot possibly identify with. However, nurses must respond nevertheless in ways that open up the possibility for address and response in efforts to restore the inner witnesses of the people they claim to serve. When subjectivity is undermined or annihilated by oppression or violence, restoring the inner witness is critical to psychic survival (Oliver, 2001). Restoring the inner witness is also crucial to restore a sense of agency that is requisite for people to take up their own resistance against oppression. Therefore, witnessing may represent an important nursing responsibility so that nurses may struggle against colonialism *with* others rather than struggle *for* others on their behalf. Arguably, it goes against nursing codes of ethics (e.g., CNA, 2017; ICN, 2021) for nurses to refuse to bear witness to the suffering of others as this reflects a moral indifference and refusal to enter into an ethical relationship with people seeking nursing care. Additionally, nurses have ethical responsibilities to alleviate social suffering and uphold the values of autonomy and justice (CNA, 2017; ICN 2021), which requires a *doing-with* approach.

Theoretical Roots of Situational Analysis and Mapping

SA developed by Adele Clarke is an extension of Strauss and Charmaz constructivist grounded theory (GT) (Clarke et al., 2016; Clarke et al., 2017). Constructivist GT is similar to traditional GT in that the aim is to produce theories about complex social processes that are grounded in qualitative data; however, constructivist GT differs from traditional GT because it acknowledges that reality is a social construct rather than objective truth, and thus the researcher is not simply a neutral observer (Charmaz, 2017). Clarke's goals when she developed SA included to push constructivist grounded theory more fully into feminist and post-structuralist terrain and to shed GT's more positivist roots. GT was initially developed by Barney Glaser and Anslem Strauss and eventually their perspectives diverged, and they pursued new scholarly partnerships for their respective work. Clarke argued that positivism is particularly evident in Glaser's strands of GT, but that it also remained more subtly in Strauss's more constructivist strands of GT. SA is explicitly located in the critical interpretive paradigm. Clarke argued that SA is particularly useful for revealing contradictions, elucidating differences, and making silences speak (Clarke et al., 2016; Clarke et al., 2017).

SA differs from GT in that the focus for theorizing shifts from social process in GT to social ecology in SA and this is reflected in the overall research questions and data analysis. An emphasis on social ecology requires analysis of complex relationships between various elements found within a broadly conceived situation (Clarke et al., 2017). Unlike traditional GT the goal of SA is not formal theory building, but rather, to "allow more flexible further theorizing downstream [that] take further changes in the situation into account" (Clarke et al., 2017, p. 16). SA draws on GT methods of data analysis such as theoretical sampling, memoing and coding, and abductive analysis; however, SA also utilizes three types of maps to analyze data (situational

maps, social worlds/arenas maps, and positional maps; Clarke et al., 2016, 2017). I will begin my discussion of methodology with a brief description of the theoretical basis of SA before moving into details around sampling strategies, data collection, and data analysis in SA and specifically how I operationalized these methods in my study.

Importantly, feminist and post-structural theoretical lenses underpin the ontological (nature of reality), epistemological (relationship between knowledge and the would-be knower), and axiological (value orientation of knowledge) assumptions of SA. Feminist research emphasizes emancipatory and transformative research aims. I will not go into details of specific feminist and post-structural scholars that informed SA. However, the critical assumptions described earlier in this chapter are also congruent with SA's critical theoretical underpinnings. For example, Clarke draws on feminist Donna Haraway's (1988) situated knowledges and understandings of objectivity that are similar to Ermine's (2007) critique of objectivity.

The following sections focus on symbolic interactionism and social worlds theory that inform SA's situational matrix and mapping methods. Constructivist GT, and by extension SA, are fundamentally rooted in pragmatism and the Chicago School of Sociology, which are also consistent with many assumptions of a critical paradigm. Researchers involved in the Chicago School of Sociology (e.g., Mead, Blumer, Dewey, and Strauss) pursued a fiercely ecological approach to sociology that focused on the whole ecological system and the niche of the individual at once in order to examine relationality within the broader social situation. Situational elements influences the positionality of people involved, the ways in which meaning is ascribed to people and behaviours, and how interactions ultimately play out. Clarke and Star (2008) called this tacking back and forth between individuals and their ecology a gestalt switch. Symbolic interactionism and social worlds theory, both of which are associated with the Chicago School of

Sociology and pragmatism, enable this gestalt switch. I will describe these theories in more detail because they are critical to understanding SA and development of my SA research project.

Symbolic interactionism attends to meaning making and construction of identities of both individuals and groups. Symbolic interactionism is based on three key assumptions: 1) people act toward *things*, including other people and objects, based on the meanings they attribute to them; 2) these meanings are formed through social interactions; and 3) meanings are then transformed through interpretive processes (thinking) that people use to understand the *things* that comprise their social worlds (Blumer, 1969). Groups make shared meanings together and engage in collective actions on the basis of those meanings. "The meanings of phenomena thus lie in their embeddedness in relationships—in universes of discourse…, which Strauss (1978) later called social worlds" (Clarke & Star, 2008, p. 114). Early researchers of the Chicago School of Sociology studied geographically bounded communities and social milieus; however this shifted to "*shared discourses* as both making and marking boundaries" (Clarke & Star, 2008, p. 115, emphasis in original). Conceptualizing nursing as a social world, rather than a shared culture, may allow for exploration of diverse perspectives within nursing that often contest each other, and also accounts for ecological situatedness. For example, attempting to locate racism as simply part of a broader nursing *culture* may be overly reductionist, homogenizes diverse perspectives within nursing (e.g., nurses of different cultural backgrounds), and risks simplifying a complex problem that is both multifaceted and deeply rooted in social structures.

Social worlds (e.g., an occupation) build common belief systems through shared commitments to certain activities and also share resources to achieve goals. Social worlds "generate shared perspectives that then form the basis for collective action, while individual and collective identities are constituted through commitments to and participation in social worlds

and arenas" (Clarke & Star, 2008, p. 116). Arenas are the broader situations where multiple social worlds encounter and interact with each other, and therefore, are often sites of contested discourses and actions. Social worlds can intersect, grow, and branch out to become arenas, for example, nursing consists of multiple diverse social worlds such as critical care or public health. Both healthcare and homelessness in Ontario more generally, would thus be considered arenas.

> Arenas are focused on matters about which all the involved social worlds and actors care enough to be (1) committed to act, and (2) to produce discourses about arena concerns. … [They are] characterized by multiple, complex and layered discourses… because perspectives and commitments differ, arenas are usually sites of contestation and controversy. As such they are especially good for analyzing heterogeneous perspectives… [and] power in action. (Clarke et al., 2016, p. 89)

SA utilizes mapping processes and tools to analyze relationalities between elements at various levels (i.e., micro/individual, meso/organizational, macro/systemic) in the situation and works to clarify which social worlds/arenas are sites of action and influence.

Defining the Situation of Action and Mapping

Defining the situation of interest is one of the initial components of SA research design. The situational matrix and situational maps are tools to support this process (Clarke et al., 2016, 2017). The situational matrix illustrates that all of the elements in the situation are not surrounding it, they are constitutive of it. I modified Clarke et al.'s situational matrix model (2016, p. 98), to be specific to my situation of action (see figure 2.1 and 2.2). The original matrix, like my modified versions, had doted lines around the elements to suggest that situations are not rigidly bounded, but rather boundaries are porous and flexible (Clarke et al., 2016). Social actions that take place within the situation (i.e., the situation of action) are placed in the

center of the figure with the elements exerting their influence and interacting to influence processes and outcomes in various social worlds and arenas.

Figure 2.1

Modified Situational Matrix and Sites of Action

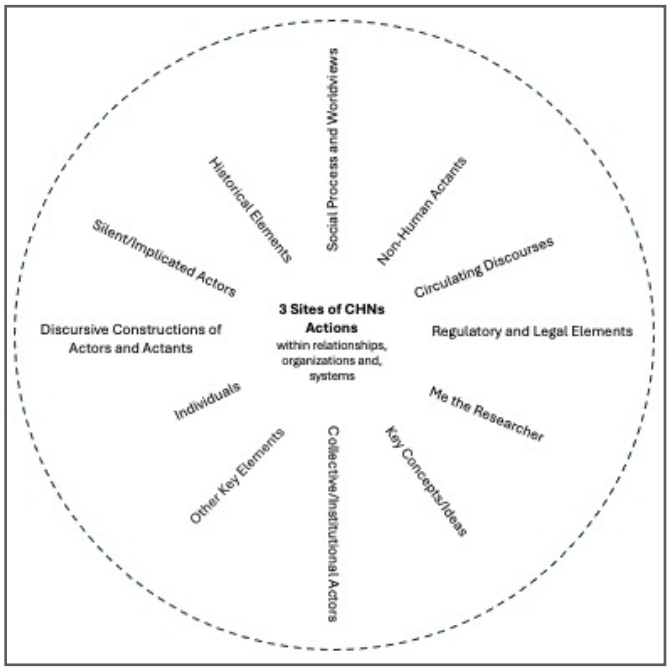
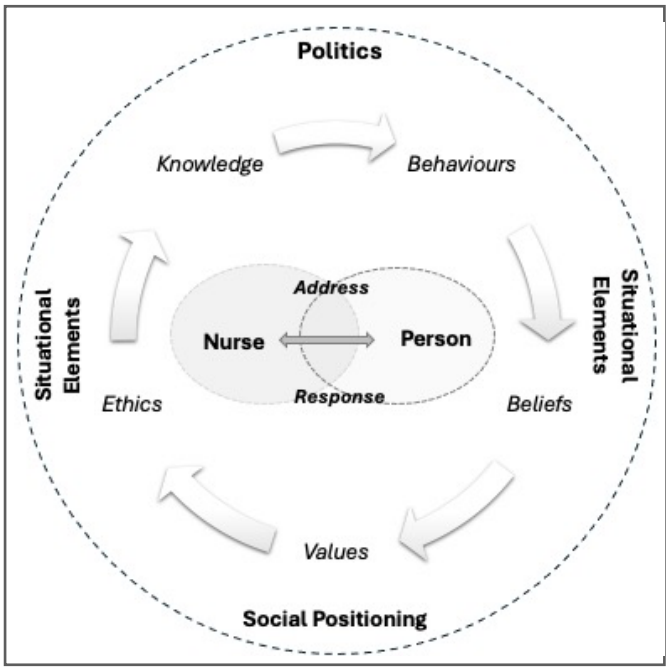


Figure 2.2

Relationships Within the Situational Matrix



Elements in Clarke et al.'s (2016) matrix included: local to global elements, sociocultural elements, symbolic elements, popular and other discourses, other empirical elements, spatial and temporal elements, human and non-human elements, political and economic elements, discursive constructions of actors, organizational/institutional elements, and major contested issues. I used Fosket (2002) as an example of how situational elements could be regrouped and tailored to the situation of interest, and I also modified my elements. In Figure 2.2, I envision the situational matrix another way, by placing the relationship in the center of the matrix I emphasize the dialogical intersubjectivity between the CHN and the person seeking care. This figure emphasizes the situational matrix interacting and influencing actions within the nurse-person

relationship. Therefore, the nurse-person relationship is at the center of the matrix with Oliver's address and response (including both verbal and non-verbal responses) moving between the two people. In the next ring the more immediate influence on address/response includes values, beliefs, behaviours and judgments, which reflect the need for relational ethics. The outermost ring represents the situation surrounding and interacting with people, their social positioning, and all of the elements in Figure 2.1, which are strongly influenced by politics. In the next section, I describe the three types of maps (situational maps, social worlds and arenas maps, and positional maps) that are integral to SA. Maps are part of data analysis but are also used to present findings.

Situational Maps. Messy maps (Figure 2.3) are typically only used in data analysis and are not used to present findings. Messy situational maps begin in mind mapping fashion by brainstorming elements that apply to your particular research situation. Figure 2.3 presents a rendering of my initial brainstorming messy map and the second image superimposed the messy map onto the social worlds and arenas as I began to organize the elements.

Figure 2.3

Initial Messy Situational and Social Worlds Maps (March 10, 2023)

This map was developed early as part of my research design. In the design stage this map helps identify everything that may be important to collect some sort of data about (Clarke et al., 2017). With the situational matrix in mind, I produced initial messy situational maps and the took all of the emerging situational elements and plotted them into the broad groups identified by Clarke et al. (2016). These broad groups were helpful, but in the end I found that re-grouping allowed for a clearer picture of my specific situation of action. My final ordered map is presented as part of my findings in Chapter four.

Social Worlds and Arenas Maps. Social worlds/arenas maps help to locate the situation of inquiry and are typically started once you have gathered some data and are beginning to understand what might be going on in the situation (Clark et al., 2017). Social worlds/arena are a broad or big picture view of the situation. The goal is relational and ecological analysis of social action by collective groups. Arenas are sites where discursive constructions about contested issues and about various actors and social worlds circulate. “The analyst needs to elucidate which social worlds, organizations, and institutions come together in a particular arena and why. What are their perspectives, and what do they hope to achieve through their collective action?” (Clarke et al., 2017, p. 155). Typically, there is one social worlds/arenas map for the project. Updating and memoing this map is important analytic work during the course of the research project (Clarke et al., 2017). The final version of my social worlds/arenas map is presented and discussed in Chapter four.

Positional Mapping and Discourses. In SA positional maps are the key analytic tools to be applied to discursive data. “Positional maps focus on issues, positions on issues, absences of positions where they might be expected (sites of discursive silence), and differences in discourses central to the situation under study” (Clarke et al., 2017, p. 165). Positions are not

linked with persons or organizations; they are positions taken in discourses. Individuals and groups commonly hold multiple contradictory positions on the same issue at the same time. Researchers should expect to do multiple versions of positional maps to show multiple ways of representing the issues. Clarke et al., (2017) suggested that positional maps are crucial to see positions not taken (i.e., silences) and analyzing, articulating, and discussing them. Identifying silenced positions ideally should lead to theoretical sampling and more data collection to ensure that the absent positions are not just missing data. The causes of silences are also worthy of speculation, for instance, would expressing the position be too political or cause social backlash (Clarke et al., 2017). People participating in the research also "in some sense produce discourse materials about the situation by reflecting on aspects of the situation" (Clarke et al., 2017, p. 219), which are analyzed using positional maps. My positional map is presented in chapter four.

Data Collection, Analysis and Ethics

The remainder of my methods section focuses primarily on data collection and analysis of my interview data using methods that are typical of both SA and GT. Similar to GT, data sources in SA typically includes in-depth interviews and may include ethnographic observations; however, unlike ethnography, observations are not requisite to GT or SA. Data collection in SA may also include extant visual, historical, and narrative discursive materials (Clarke et al., 2017). According to Clarke et al. (2017) SA projects may focus solely on interview data collected by researchers and analyzed using GT constant comparison methods. Alternatively, researchers may analyze only extant discourses materials as part of a single sited approach to SA (e.g., analysis of marketing materials for a particular public health campaign). Finally, multi-sited approaches to SA may combine interview data with extant narrative, visual, or historical discourse materials, which is typical of larger more complex studies.

I used in-depth interviews of CHNs as my primary data sources. CHNs all worked in harm reduction programs (e.g., CHCs, safe consumption sites (SCS), safer supply programs, supportive housing, and outreach into shelters). Secondary sources included publicly available extant discursive materials including websites, nursing documents, media articles and extant literature. Collection of extant discursive data are detailed in the data collection section. Due to the complexity of the problem and my research question, I felt that both interview and extant discursive materials would be important. For example, interviews alone would be unlikely to reveal all the potential situational elements that could or should influence nurses' anti-colonial struggles. I wasn't sure at the outset what types of discursive data would be readily available and how useful they would be. I identified potential new sources of data and pursued new lines of inquiry as the study progressed, which is consistent with theoretical sampling and typical of GT methods (Charmaz, 2017). In GT and SA, data collection and analysis proceed concurrently with each informing the other. Data collection and analysis are an iterative process and cannot be fully predicted or predetermined at the outset of the project.

Conducting formal observations were not feasible for my project because it may have posed ethical and logistical challenges. Ethically, many interactions between nurses and vulnerable clients are sensitive and an outside observer could impede nurses' work or make clients uncomfortable both of which could negatively impact care. Additionally, it is highly unlikely that organizations would give consent for a researcher to conduct observations if they believed that researchers could intentionally or inadvertently expose culturally unsafe care or racism. Similarly, EMRs would be a rich source of extant discursive data, but again it is unlikely organizations would consent to having a researcher look through charts given my topic explores racism. However, I have the benefit of insights gleaned from my work experience in harm

reduction that other researchers may not, which makes direct observations less critical.

Ethical Considerations

Ethical approval is required for interviewing human participants, but not for analyzing publicly available, extant discursive materials. I submitted an ethics application to the University of Ottawa Health Sciences and Science Research Ethics Board (REB) and obtained approval. None of the community health organizations had their own REBs and I obtained permission from leadership from the participating organizations prior to recruiting participants. Informed consent, which included discussing any potential risks and benefits, was obtained from participants prior to conducting interviews. Potential risks for participants included social repercussions (e.g., possibility of marginalization, being negatively judged by peers or employer), psychological or emotional discomfort (e.g., anxiety, loss of confidence, regret for disclosing information), and inconvenience (e.g., time consumed to participate in interviews or travel to meet for interviews). Additionally, every effort was taken to minimize potential social repercussions. I anonymized the data to the extent possible to protect the identities of research participants and I will not name the city in the publications (i.e., research took place in an urban center in Ontario). I did not anticipate any physical or emotional harm (e.g., to experience trauma or re-traumatization related to interview questions) and this remained the case throughout interviews.

I suggest that the actual risks of not doing anti-racism research, which includes the risk that nurses unknowingly perpetuate harm against Indigenous Peoples or fail (through their silence and inaction) to address anti-Indigenous racism and health disparities, clearly outweighed the potential risks (e.g., social repercussions, emotional discomfort) to CHNs participating in interviews. Additionally, participants expressed that they appreciated the opportunity to talk about cultural safety and reflect on the care their Indigenous clients received at their

organizations. Participants also expressed that they wanted to learn more about cultural safety and anti-Indigenous racism and appreciated the opportunity to discuss nursing practices and expand their own nursing knowledges about racism and oppression.

My research was intended to be strength-based and contribute to emancipatory and transformative nursing knowledge. However, despite good intentions of CHNs, nurses do not exist outside of settler society. Nurses including myself are all, in various ways and to varying degrees, complicit with systemic racism. As mentioned previously, there are risks that my study could amplifying already privileged voices, inadvertently perpetuate racism, and misappropriate Indigenous knowledges and theories. A critical lens seeks to uncover taken for granted assumptions and discourses that maintain settler colonial dominance, and identify complicity with practices, policies, and systems that cause harm to Indigenous Peoples. I engaged in cultural humility and utilized my thesis advisory committee members to engage in reflexive discussions. Arguably it could be an ethical weakness that I did not have community advisory members inclusive of Indigenous people with lived experience of homelessness. However, the pandemic and COVID 19 related restrictions caused certain challenges to engage community members during the development stages of this project. Additionally, decisions around seeking people with lived experience to serve as advisors were balanced with the ethical issue of asking financially vulnerable people to volunteer their time because I did not have funding.

Interview Sampling Strategies

Interview participants were primarily engaged through email and permission was sought from employers to send group emails to CHNs' organizational email accounts and to conduct any interviews during work time or on work sites. Word of mouth was also used to engage participants and this did not require employer permissions, provided interviews were conducted

off site during non-work hours. SA does not provide guidance on sample size. However, I estimated a sample size of 10-20 participants would be required for my project. CHN participant selection was based on whoever volunteered first. Recruitment was stopped at 10 participants because more than sufficient data was obtained. Additionally, recruitment of front-line CHNs was progressing with some difficulties given few organizations had consented to participate. More generally, there are also few front-line CHNs in this medium sized city that work primarily with the homeless community and front-line staff had their own time and workplace constraints to participate during work hours. In consultation with my thesis advisor, we determined that we were within the range of the estimated sample size (10-20 CHNs) and any additional interviews would be unnecessary for the scope of the project.

In GT and SA, research participants and other discursive data are purposively selected based on emerging theoretical insights from the data. Theoretical sampling differs from random sampling that is typical of quantitative methods and snowball or convenience sampling that is typical of many qualitative studies where sampling and data collection are completed prior to starting data analysis (Charmaz, 2017). My data collection and analysis proceeded concurrently. In SA heterogeneous perspectives and thick descriptions are desirable and sought after. However, unlike GT, theoretical sampling in SA may not result in data saturation because of the diversity of perspectives. Diverse perspectives of the situation are sought and this may be achieved by identifying key-informants (similar to ethnography) based on their knowledge of the social worlds, arenas, and situation of interest. There were constraints on approaching participants directly to request that they participate in my research due to obtaining organizational permissions and limitations imposed by the REB to ensure participants volunteered without inadvertent pressure or coercion to participate.

I obtained informed written consent prior to conducting interviews. I mostly conducted in-person interviews, but accommodations were made for virtual interviews. One participant chose to participate via MS Teams and one participant participated via phone. Both of these participants provided consent forms via email and confirmed verbal recorded consent prior to the start of the interview. Three CHNs participated outside of work hours, because of their time constraints and difficulty finding time during work hours. Interviews were audio recorded.

I developed an interview guide at the start of the project. The guide was minimally revised as theoretical sampling progressed. The interview guide was designed using broad open-ended questions. The first part of the interview focused on participants' perception of the problems associated with Indigenous homelessness including the oppressions facing their clients, barriers to care, and whether or not they perceived that Indigenous Peoples had equal access to their organization's services. The second part of the interview focused on how participants were responding to the complex issues that they described including their advocacy work and how they responded to racisms that they witnessed or encountered in their nursing practice. The final part of the interview focused on CHNs' understandings of theoretical concepts such as cultural safety, cultural competency, human rights, treaties, and truth and reconciliation. In, addition to exploring CHNs' understandings of these concepts, I also tried to discern throughout the interview if/how this theoretical knowledge informed the anti-oppressive nursing practices that they described. Theoretical insights were becoming apparent early in the process of conducting interviews as data analysis proceeded simultaneously with data collection. My skill in conducting interviews also improved as the study progressed. Therefore, I was able to tailor questions based on emerging insights to achieve greater depth and explore silences in the data.

Collecting Extant Discursive Information

Literature searches were undertaken to identify research gaps and develop my proposal. Extant literature was a critically important part of my analysis in chapter three to provide in-depth understandings of systemic racism, racist policies, and histories of colonialism in nursing. Systematic review methods were not feasible given the complexity of my topic and intent to provide a relational ecological overview. My approach meant that I needed fewer studies in one area, but many studies overall, and in multiple different areas (e.g., cultural safety, racism, colonialism, harm reduction, Indigenous homelessness). For example, it would not have been feasible to undertake systematic searches with broad search terms such as nursing and racism, because it would have retrieved an exhaustive amount of literature. Existing systematic reviews were sought to understand the state of research into racism and colonialism in nursing and their reference lists were invaluable. Additionally, empirical studies on colonialism in nursing were problematically hard to locate, although a few did exist (Bryder, 2018; Hawkins & Sweet, 2014; Krik, 2022a, 2022b; Nestel, 1998; Rafferty & Solano, 2007; Schuelke, 2017; Schultheiss, 2010; Sinha, 2017). Some of these articles also led me to historical documents related to nursing. I undertook multiple smaller searches in Google scholar often trying various combinations of search terms. Google scholar typically returns many pages of citations; therefore, I would review at least the first 5 pages of each search and then stop when relevance started to decline. When I found relevant articles, I utilized ancestry citation searches in Google scholar and undertook in-depth reviews of all of the reference lists. All relevant citations were imported by hand into Endnote and organized thematically. Full texts were then downloaded, analyzed, and annotated.

Circulating discourses in the media were also an important part of my study. From the start of the project and on a near daily basis, I watched for media articles and press releases in

my Apple News feed. Apple News is algorithmic based and entails unknown bias; however, it allowed me to follow news in real time compared to periodic database searches. Other strengths were that it offered a wide range of media outlets across the political spectrum (e.g., National Post (conservative right), Guardian (progressive left), Toronto Star (centrist)). Apple News is limited with regards to Indigenous media outlets, but I was able to follow APTN. I could also select topics to follow, including homelessness and substance use. I read and saved articles on harm reduction, homelessness, and racism in healthcare. In particular, I looked for articles that presented politicians' statements and perspectives of concerned community members, nurses, harm reduction leaders, people with lived experience, and community health organizations.

I was able to amass a collection of articles that provided a broad overview of the situation and a sample of some of the circulating discourses and polarizing debates among politicians, the public and particularly prominent news media influencers and opinion pieces. I also undertook an exhaustive and systematic search of academic articles that analyzed Indigenous issues in Canadian news. The searches are not presented here and it is part of another project. However, these searches gave me a broader understanding of media representations of Indigenous Peoples, and usefully returned a few articles related to substance use (Johnston, 2020; Nelson et al., 2016) and one article on homelessness (Challand, 2023). Early in my doctoral studies, I searched websites of nursing organizations and regulatory bodies to look for anything that should guide nurses' anti-oppressive actions. These searches were repeated annually over the course of my project and are detailed in Chapter five.

Data Analysis

Data analysis begins at the outset of SA and is part of research design. To begin the study, I drew on extant literature, media articles, and my own informal ethnographic observations as a

practicing CHN to explore the sociocultural elements, historical elements, political economic elements, popular and other discourses, major contested issues, and discursive constructions of actors. The situational matrix lays out important elements in the sociopolitical arena of Ontario healthcare that influence the social worlds of community health nursing and Indigenous homelessness. Although, these elements are critical to understanding the situation, they did not all emerge during the interviews with CHNs. How these elements emerged during interviews in comparison to the earlier analysis was a focus of data analysis and informed the final SA maps.

Three alternatives to analysis include induction, deduction, and abduction (Clarke et al., 2017). Many researchers maintain that qualitative research is inductive. In analytic induction, theory *emerges* from the data, which presumably is possible because the researcher enters into analysis as a blank slate with no preconceived ideas. Deductive reasoning is most often used in quantitative research that involves hypothesis testing (i.e., researchers develop a theory and then data is collected to test that theory). Clark et al., (2017) described that SA and later versions of Strauss's GT draw on abductive analysis where the "researcher *tacks back and forth* between the nitty-gritty specificities of *empirical* data and more abstract conceptual ways of thinking about them… Over time… the analyst *conceives, refines, selects, rejects, and ultimately connects robust concepts toward theorizing* a substantive area" (p. 28, emphasis in original). Abductive reasoning, therefore, does not assume theory emerges from data. Researchers actively pursue lines of inquiry and theorize based on previous work in the substantive area. From a feminist perspective, it is irresponsible to suggest that researchers can be objective, unbiased observers. We all come to research projects as active participants with prior ideas and experiences that inform the ways in which we see the world (Haraway, 1988). This is particularly so for nurses

conducting research related to their clinical practice area. Tabula rasa is not possible, nor is it desirable to forgo reading substantive literature prior to conducting a study.

Interviews were audio recorded and after each interview, I wrote notes (i.e., memos about the interview). I then transcribed the audio recordings word for word and this process helped to familiarize myself with the data. I uploaded the written transcripts to NVivo to facilitate data analysis. Discourses are particularly salient in SA; however, formal discourse analysis is not requisite to all SA projects. Data analysis in both GT and SA utilize memoing and coding in a process of constant comparison (Charmaz, 2017; Clarke et al., 2017), which I also implemented in my project. I utilized only the basic features of NVivo to organize transcripts, write memos and manually develop and assign codes to interview text. Once transcripts were uploaded to NVivo, I read them again while listening to the transcripts. Coding is a process of developing substantive codes that reflect key ideas in the data. During analysis of narrative data (e.g., interview transcripts or extant written materials) coding is typically done as the transcripts or documents are read line by line. I assigned a core idea, concept, or code to each line, constantly comparing to previous data and codes. Substantive codes are clustered and translated into each other to generate sensitizing concepts, categories, and emerging themes (Charmaz, 2017; Clarke et al., 2017). Relationships between codes were analyzed and memos written as part of the theorizing process, in GT this is called axial coding (Walker & Myrick, 2006). Memoing is the process of writing notes or theoretical reflections about the data. In GT, memos should be written during field work, during or immediately after interviews, and during analysis of interview transcripts. In SA memos are also written during the mapping exercises. Without memoing, the theory that is produced is typically superficial. Theoretical depth can be achieved by looking back on memos and reflecting on the accumulation of theoretical insights (Clarke et al., 2017).

I integrated informal observations into data analysis of interview transcripts; although, I did not conduct formal observations or take observational field notes while I was working as a harm reduction nurse. To be honest, at the end of an exhausting workday I simply did not have time or headspace to make reflexive field notes, nor did I have ethical approval for observational research. An absence of time spent conducting formal ethnographic observations is arguably a methodological weakness. However, three and a half years is considerable time "in the field" of harm reduction for ethnographic insights to emerge. Additionally, I engage in reflexivity and praxis regularly as part of improving my nursing practices and I have since I was a nursing student. During the interviews as well, my knowledge from clinical practice generated insights, led to more informed follow-up questions and contributed to the richness of data. I made notes after each interview and as I read the transcripts. I compared and contrasted what CHNs were telling me to what I had witnessed in my own nursing practices, not just in harm reduction, but also across my almost 20 years in nursing. I made memos of these reflexive insights consistent with SA/GT data analysis described above.

There is a risk with this analysis that I could amplify problematic nursing discourses about Indigenous Peoples and homelessness. Drawing on discourse analysis, which is part of SA, I spent considerable time listening to the interview recordings while I read and re-read the transcripts focusing on patterns of speech, pauses, hesitations, and analyzing silences. I focused on how things were said and what was not said because this was at times more insightful than what was actually said. A basic thematic analysis would have been insufficient in this regard.

Situational maps helped me to integrate interview data with extant discursive data and my informal observations. These maps continued to evolve throughout theoretical sampling, data collection, and analysis as is typical of SA (Clarke et al., 2016; Clarke et al., 2017). The process

of working between messy and ordered maps helped to identify elements that I may not have considered in the initial brainstorming phase, new lines of inquiry, and things that seemed particularly relevant to pursue data about. I continued to modify these maps throughout the research process. I highlighted particularly relevant elements that emerged during interviews and in media articles. I looked for relationships between elements and identified how important elements fit together and continued grouping and re-grouping elements until some underlying themes emerged. I turned from interview data and reflexive observations to also include discursive materials (e.g., media articles, RN and CHC websites) in the mapping exercises.

Relationality between elements on the messy situational maps were explored during data analysis by drawing lines between each and every element and using data to ground theoretical insights about the relationship (Clarke et al., 2016, 2017). This process may be particularly salient to identify conditions that constrain or enable anti-colonial struggles in CHN practice, because conditions may relate to situational elements. Relationality between situational elements, circulating discourses, human and non-human actors/actants, and ecological situatedness are thus a key focus throughout the creation of social worlds/arenas and positional analytical maps, which I will discuss in more detail in Chapter four when I present the final versions of these maps with my research findings. I combined all of my various forms of data into the relational ecological overview. However, interview data was largely analyzed separately from extant discursive data as is the recommendation by Clarke for novice researchers including doctoral students. I drew on discursive materials as supplementary source of data and to expand understandings of the situation. Analysis of media and other narrative discursive materials was conducted in similar fashion to doing a literature review for the background chapter of a doctoral thesis, and were not intended to be a full study in itself.

Summary of Methods

To summarize my methods, I began my SA project by developing a messy situational map and initial ordered situational map. Throughout the research process situational maps evolved and also facilitated theoretical sampling (Clarke et al., 2017). Messy situational maps were translated into a narrative list that Clarke et al., (2016) called an ordered situational map. Clarke et al. suggested that going back and forth between messy and ordered maps may be useful to generate theoretical insights about the situation of interest. Situational maps were used to identify sources of data and to begin a process of theoretical sampling for interviews and sources of discursive data. I primarily collected data through in-depth interviews with CHNs. Extant discourse data including websites and media articles formed a secondary and minor component of the final analysis. I utilized GT memoing and coding to analyze interview data and utilized theoretical sampling to refine my interview guide and identify additional potential participants. I developed a social world map once I had a sense of what was going on in the situation and continued to use the messy and ordered situational maps to analyze relationality in the situation. Positional maps were used in late stages of analysis to articulate discursive positions in the data. I believe that SA was congruent with my theoretical framework. I have also aptly demonstrated that symbolic interactionism and social worlds theory provided an analytic frame for my research questions and objectives. SA combines the analytic strength of GT with an explicitly feminist approach to research that, importantly for my research is democratizing and inherently emancipatory. The next chapter begins my SA findings. With an anti-colonial lens, I explore anti-Indigenous racism and racist policies in the realm of harm reduction and homelessness through analysis of extant discursive data including news media and academic literature.

Chapter Three: On Angels and Vices—Colonial Systems and Social Control

On September 28, 2020, my wife, the mother of my children, was torn from us in inhumane circumstances that we all witnessed. Joyce's death was a terrible tragedy for our children and me. I hope the governments of Quebec and Canada will adopt Joyce's Principle so this terrible event did not occur in vain. Let her voice be the beginning of real change for all Indigenous people so no one ever again falls victim to systemic racism.

Carol Dubé – Joyce's Husband, as cited in Joyce's Principle (2020)

Joyce Echaquan was an Atikamekw woman and mother from the First Nations community of Manawan. Her death at Centre hospitalier de Lanaudière (Joliette Hospital) in Lanaudière, Quebec on September 28th, 2020 was directly attributable to racism (Kamel, 2020). Just moments before she died, nurses hurled racist insults while Joyce[3] was suffering and in pain. Unfortunately, nursing transgressions such as these are not limited to Joliette Hospital and Joyce's experiences are not an isolated incident (Allan & Smylie, 2015). In this case, however, nurses were graphically and publicly exposed on camera engaging in anti-Indigenous racist actions (Kamel, 2020). Although Joyce's death occurred in Quebec's acute care system, the sociopolitical elements and circulating discourses about racism in healthcare are relevant to my situational analysis. Joyce's story revealed a lot about the dire situation of anti-Indigenous racism in Canadian nursing and settler narratives about Indigenous Peoples and substance use. In addition to the overtly racist comments and slurs, nurses also delayed interventions that could have saved Joyce's life because they falsely assumed she was suffering from drug and alcohol withdrawal. These deadly but all too common stereotypes have led to the death and maltreatment of many Indigenous people by nurses and can be traced at least as far back as Nightingale and

[3] I refer to Joyce Eschequan by her first name in an attempt to humanize her, despite her dehumanizing treatment in healthcare. The use of her first name is also in keeping with the name of the principle that memorializes her brave attempts to hold nurses and doctors accountable for their racism. Referring to her by her first name is not intended to be disrespectful, informal, or imply that I knew her personally.

the height of European colonialism. Understanding narratives about Indigenous Peoples and substance use are relevant to harm reduction and the struggles faced by CHNs in my study to provide equitable care and ensure their clients' needs are met when they access acute care.

I began with the story of Joyce Echaquan and the year 2020 for a number of reasons. In 2020, with my PhD underway, I was thinking deeply about how to approach the problem of Indigenous health disparities and Joyce's death had a profound impact on my thinking about systemic racism. My academic readings influenced my understanding of what I was witnessing in the world. The year 2020 and the global COVID 19 pandemic laid bare racial health disparities. Joyce's death also occurred in the same year that George Floyd was killed in the US. The death of a Black man at the hands of White police officers was far from a novel or isolated incident. However, similar to the nurses 'caring' for Joyce, the overtly racist and fatal actions of police were also caught on camera, which was significant because it led to global protests (e.g., Black Lives Matter) against systemic anti-Black racism and White supremacy. The events of 2020 prompted what many people, including nursing scholars, described as a long overdue racial reckoning (Canty et al., 2022; Collier-Sewell, 2023; Myers, 2022).

Unfortunately, since 2020 the world has now seen an immense amount of conservative backlash against anti-racism and anti-colonialism work, diversity, equity and inclusion (DEI) efforts, and anti-racism training based in critical race theories (Muñiz, 2024). For example, large corporations have been rolling back DEI efforts for a few years in response to so called anti-woke culture. US president Donald Trump, in his first weeks of power, unilaterally signed executive orders to dismantle and rid the US government of any trace of DEI and even falsely blamed DEI for a tragic and fatal plane crash (Senger, 2025). It remains to be seen the impact that Trump's racist actions will have on Canadian politics. Additionally, there is considerable

backlash in Canada against harm reduction work (Michaud et al., 2024) and Indigenous rights (Spitzer, 2024). I argue that concurrent backlashes against Indigenous rights, anti-racism, and harm reduction are rooted in the same social processes and ideologies, which will be discussed in this chapter. These concurrent backlashes are the backdrop of CHNs anti-colonial struggles.

This chapter moves through a detailed analysis of systemic racism, insidious systems of White supremacy and nursing histories of colonialism. I explore present day continuities with these histories including within harm reduction, homelessness and substance use policies. I draw on extant academic literature, as well as news articles that described public perceptions, politicians, and media comments about harm reduction and people experiencing homelessness. Based on this analysis, I build arguments about how seemingly race neutral policies are actually racist and highlight some of the White racial behaviours that uphold systemic racism in nursing, healthcare, and Canadian society more generally.

Histories of Settler Colonialism and Continuous Harms

The ideology of White supremacy was part of the impetus of European colonialism, which installed systems of governance around the world that privileged people of European descent and allowed for their economic wealth advantages to grow exponentially over other racial groups. By the 1930's, European colonialism involved 84.6% of land around the world (Loomba, 2015, p. 36) and "everywhere it locked the original inhabitants and the newcomers into the most complex and traumatic relationships in human history" (Loomba, 2015, p. 20). Systems and structures erected by White European colonizers, with few exceptions, have not been dismantled and benefits continue to accrue among White people at the expense of Indigenous Peoples (Russell, 2020; Wolfe, 2006). Residential schools' policies designed to assimilate Indigenous children are becoming more well known, but many other Canadian

policies were also intended to assimilate, segregate, and criminalize Indigenous Peoples. For example, disproportionate racial harms related to the criminal justice system that we see today among Indigenous Peoples were not an accidental outcome of policies in Canada (Marshall, 2015). Kendi (2016, 2019) argued that policies are rarely ever race neutral. Policies are either anti-racist or racist. I agree and suggest that encampment sweeps and many drug policies are racist, simply because they disproportionally impact Indigenous people. Moreover, historically many policies related to substance use and law enforcement were formalized and official state policies of assimilation and segregation (Godkhindi et al., 2022; Marshall, 2015).

Canada's substance use policies are rooted in White supremacy and are an example of how colonial policies of segregation and assimilation continues to reverberate in present day Canadian systems and structures. These policies encompass control over substances that are currently legal and have been subject to various restrictions or prohibitions throughout history (e.g., alcohol, cannabis, nicotine), substances that are currently illegal to possess under the criminal code (e.g., cocaine, heroin, hallucinogenic drugs, methamphetamines, non-pharmaceutical grade fentanyl) and other substances (e.g., benzodiazepines, opiates) that are only legal to possess and use with a prescription under medical direction. There are many health-related harms of current substance use policies that I highlight towards the end of this section.

Many nurses may be unaware of how colonialism and White supremacy were inherent in the history of substance use policies. Despite my work as a harm reduction nurse, I really only became more aware of the racism inherent to substance use policies late in this study. I began to dig deeper into this history when CHNs suggested that substance use stigma was a somewhat race-neutral phenomenon among all of their clients experiencing homelessness. Therefore, I begin with a brief introduction to histories of substance use policies in Canada and the US. There

are many similarities and differences between the two countries. However, Canada faces pressure to conform to US drug policy due to international free trade agreements and the longest shared unprotected border in the world. For example, US president Donald Trump used the Fentanyl crisis and critiques of Canada's supposed lax border and drug enforcement to impose trade tariffs, despite that illegal drugs (and guns used by violent gangs involved in the drug trade) are more likely to enter into Canada over the shared US border than the reverse (Tasker, 2025). Trumps actions may worsen harm reduction backlash in Canada and set back progress on harm reduction nurses' drug decriminalization efforts.

Racist Roots of Harmful Substance Use Policies

Colonial histories and White supremacist motivations behind racist drug and alcohol policies clearly indicated that racial harms were intended. Prohibition was also bound up with Christianity and control over people and behaviours deemed to be immoral. Church and state were deeply intertwined in the rise of colonialism. Godkhinidi et al. argued that in Canada and the US "prohibition was spurred by fears of racial integration, Indigenous sovereignty and the 'non-British other' threatening White middle-class purity. The development of punitive drug policies originated as a tool to repress racialized communities and further colonial dispossession" (2022, p. 3). Not surprisingly, racism was built into the system from the start of Canada's state control over drugs and alcohol and informed prohibitionist policies. Alcohol policy in Canada has a long racist history that was different from the US because it was bound up with the *Indian Act* (Campbell, 2008). Racist anti-Indigenous discourses and stereotypes in healthcare often revolve around alcohol use (Government of British Columbia, 2020). Therefore, it is particularly important for nurses to gain better understandings of this history and the harm it caused.

Indigenous Peoples were restricted from purchasing or consuming alcohol in Canada for

protracted periods, subjected to race-specific regulations by colonial-state authorities from 1777 to 1985 (Campbell, 2008). Alcohol prohibition laws were written into the *Indian Act*, with intent to further policies of assimilation and segregation and these laws did not apply to White settlers (Campbell, 2008). Campbell (2008) described how the *Indian Act* was amended in 1884 to prohibit the sale of alcohol to Indigenous Peoples and allowed for colonial authorities to further repress and control Indigenous Peoples, but it also bolstered an assimilationist agenda.

Citizenship was withheld from an Indigenous person unless they could prove that they were capable of being a 'sober citizen'—a condition for citizenship that was not required of White settlers (Campbell, 2008). Moreover, Indigenous people would need to give up their protected status and rights under the *Indian Act* in order to become a Canadian citizen and thus be legally allowed to consume alcohol in the first place. Persons who were not legally "Indians" whom, simply, associated with Indigenous people or cultures were also prohibited from buying alcohol, which was a policy intended to assimilate and segregate (Campbell, 2008). Selective prohibition of alcohol on the basis of race continued even after the *Indian Act* was amended to eliminate these sweeping prohibitions for Indigenous Peoples (e.g., Ontario's interdiction list commonly referred to as the "Indian List"; Genosko & Thompson, 2006; Valverde, 2004). Some Indigenous communities continue to prohibit alcohol possession (i.e., dry communities); however, these community level policies are different from state imposed alcohol prohibition because decisions are typically made by communities with consensus about what is in the best interests of their own community (Davison et al., 2011). Additionally, community control over all types of policy making supports UNDRIP and Indigenous sovereignty.

State prohibition of alcohol is not the only example of racist substance use policies. Canada's *Opium Act* was passed in 1908. This act is relevant to the current opiate crisis, and the

act was also rooted in racism (Godkhindi et al., 2022; Michaud et al., 2024). Chinese immigrants were predominately in control over opium trade and operated opium dens in Canada. Smoking opium was largely associated with Chinese culture. Canada was one of the first Western nations to pass legislation controlling opiates, and they did so as a repressive tool to control Chinese immigrants (Godkhindi et al., 2022; Michaud et al., 2024). The US followed suit in 1914 with the *Harrison Narcotics Act*, which controlled the sale and production of opium and coca leaf (from which cocaine is derived), and prohibited their use outside of healthcare; additionally, coca leaf was used in Indigenous societies in parts of the Americas (Rosino & Hughey, 2018). Cannabis was prohibited in 1937 in the US with the intent to target Mexican immigrants; moreover, the drug was branded as Marijuana to associate it with Hispanic language and culture (Rosino & Hughey, 2018). During the 1980's so called crack crisis in the US, laws were created with racist intent to target and police Black communities that were more likely to use crack (Michaud et al., 2024). Lawmakers treated crack cocaine more harshly than powdered cocaine; meanwhile, powdered cocaine was typically used by White upper classes and also carried lesser prison sentences and penalties upon criminal conviction (Godkhindi et al., 2022).

The war on drugs and tough on crime US rhetoric was mirrored in Canadian laws and policies. Prime Minister Mulroney implemented a National Drug Strategy in 1987 that increased surveillance of street level drug offences and increased funding and powers of police (Godkhindi et al., 2022; Michaud et al., 2024). Prime Minister Harper (2006-2015) continued with a series of 'tough on crime' enforcement policies and funding cuts for harm reduction; furthermore, Canada's tough on crime rhetoric disproportionately impacted Indigenous people experiencing homelessness, street involvement, and substance use (Marshall, 2015). Some substance use laws may not have explicitly mentioned race, but their original intent, as described above, was to

further racist political agendas and social control over racialized groups. Application of these laws disproportionately policed, imprisoned, and controlled Indigenous, Black, Hispanic, and Asian communities in the US and Canada (Godkhindi et al., 2022; Michaud et al., 2024). Most prohibitionist drug laws in Canada (except alcohol and cannabis) are still in effect.

Health Related Harms Associated With Substance Use Policies

Substance use policies and their related enforcement practices were historically used to criminalize Indigenous Peoples and other racialized communities, which has intergenerational impacts on health and wellbeing. For example, rates of incarceration for Indigenous Peoples are higher than for both White and Black people in Canada. Some estimates suggested Indigenous Peoples are overrepresented in the federal prisons by over 600% compared to White people, which is approximately double the rates for Black Canadians, whom are overrepresented by 300% compared to Canadian rates overall (Godkhindi et al., 2022). Causal relationships between incarceration and long term health impacts are confounded by pre-existing disparities in SDH and a lack of longitudinal data; however, direct negative impacts on health include: emotional trauma, social isolation, exposure to violence, infectious disease (e.g., tuberculosis (TB) from overcrowding) and policies or individual staff that withhold screening or supplies to prevent transmission of sexually transmitted and blood born infections (STBBIs) and drug overdose (De Shalit et al., 2024; Lacombe, 2023; Massoglia & Remster, 2019; Ricciardelli et al., 2024; Whitten et al., 2023). Prison sentences and criminal records have long term impacts on SDH with difficulties obtaining housing and employment after release, and lost earning potential during and after incarceration that can impact future generations (Massoglia & Remster, 2019). Therefore, we can safely assume that substance use policies that disproportionally criminalize Indigenous

people and the resulting intergenerational impacts on their SDH (e.g., poverty, housing security) are partly to blame for health inequities between Indigenous Peoples and settler Canadians.

Harm reduction nurses have fought for decriminalization of substance use on the basis of health equity. For example, the Harm Reduction Nurses Association (HRNA) successfully initiated legal action against British Colombia (BC) in HRNA v BC. (2023) on the basis that *Restricting Public Consumption of Illegal Substances Act*, S.B.C. 2023, c. 40 (the Act) violated the rights of people who use drugs, disproportionately harmed Indigenous people, homeless communities and harm reduction nurses, and violated the 1982 *Canadian Charter of Rights and Freedoms* (i.e., The Charter; HRNA v BC., 2023; Kelsall et al., 2025). BC courts upheld the initial temporary injunction and the Act was officially repealed in December 2024; however, BC then turned to the Canadian federal government to "adapt their collaborative decriminalization framework for possession to only apply in private residences" (Kelsall et al., 2025, p. 2).

In principle, Canadian substance use laws currently apply equally to people of all racial backgrounds. In practice, there are racial disparities in the application of some laws. Informal law enforcement practices include racial profiling and targeted policing of Indigenous people and other racialized groups, although most law enforcement agencies deny these racist practices (Samuels-Wortley, 2021; Wiese et al., 2023). Additionally, substance use policies including federal laws that criminalize certain drugs (e.g., cocaine, opiates, methamphetamines) and provincial and municipal laws banning consumption of alcohol in many public places, often disproportionately target people who are homeless, in part because they have no choice but to use in public spaces rather than the privacy of their homes (Kelsall et al., 2025; Olson & Pauly, 2021; Pauly et al., 2016). People enjoy relative seclusion from police when they use in the privacy of their homes, because it is less overt and out of sight of police and the public (Kelsall

et al., 2025), but also because of the relative absence of police surveillance in White suburban and wealthier neighborhoods (Samuels-Wortley, 2021; Wiese et al., 2023).

White middle/upper classes benefit from informal decriminalization, while Indigenous people living in poor urban areas and homeless on the streets bear a disproportionate burden of harmful drug policies (Godkhindi et al., 2022; Marshall, 2015). Homeless encampments are contentious and public pressure to dismantle them often occurs, in part because of people's more visible use of illicit substances and presence of discarded drug paraphernalia within and around encampments (Benzie, 2024a; Benzie & Ferguson, 2024; Braimoh et al., 2023; Olson & Pauly, 2021). Encampment sweeps are typically municipal enforcement practices that push people further into the margins and increase their risk of overdose deaths and exposure to the elements (Chang et al., 2022). These types of policies and practices are far from race neutral, given the disproportionate burdens of homelessness born by Indigenous Peoples (Government of Canada, 2023). Informal decriminalization and under-policing for some versus legal punishments and greater social stigma for others reveals the ongoing racism and classism of substance use policies and enforcement practices (Kelsall et al., 2025; Virani & Haines-Saah, 2020). Police and criminal justice systems are not the only tools of social control utilized by settler colonialism—nurses are perceived as benevolent and angelic actors, but nonetheless they served the civilizing mission to control Indigenous Peoples, reform them to Christian moral standards, and assimilate them into White settler societies (Nestel, 1998). I turn next to explore nurses' historical roles in colonialism and connect this with present day harms in nursing including substance use stigma.

Nurses Roles in Colonialism

Historically, many nurses in Canada worked in community settings (e.g., district and outpost nurses) and CHNs' work was more nuanced than the sections that follow might suggest.

Indigenous nurses were, and continue to be, a formative part of community health nursing in Canada and include historical leaders such as Charlotte Edith Anderson Monture and Jean Cuthand Goodwill (Bourque Bearskin, 2023). Indigenous nurses fought for decades and continue to fight against colonial oppression (Best & Stuart, 2014; Bourque Bearskin et al., 2025; Canadian Indigenous Nurses Association, 2016; Dion Stout, 2012; Dion Stout et al., 2021; Downey, 2014, 2020; Fraser, 2022b; Hurley, 2024; Kelly, 2024; Kelly & Chakanyuka, 2021). Despite attempts by colonizers to eliminate their ways of knowing, Indigenous nurses worked to maintain and transmit Indigenous healing and midwifery practices within their communities and provided both "Western" and Indigenous medicines (Burnett, 2010; Downey, 2014; Hurley, 2024; Sanders, 2021). They also supported the health and well-being of settlers in rural and remote areas (Burnett, 2010; Kelm, 1994). Some settler CHNs worked alongside with Indigenous nurses and midwives and learned from them about Indigenous health and healing practices (Elliott et al., 2009; Kelm, 1994; Patton & Kaliel, 2020; Schuelke, 2017). Other CHNs (e.g., Grey nuns) motivated by religion did outreach work into impoverished urban communities with sex workers and other marginalized people and this is the roots of modern day Canadian street nursing (Hardill, 2007).

Nurses occupied complex social positions and we cannot ignore their oppressed positions as women within colonial societies and medical systems that were and still are hierarchical and based in patriarchal male norms—this is an area of study in itself (Bryder, 2018; Krik, 2022a, 2022b; Nestel, 1998). Additionally, the work of Indigenous nurses, past and present, deserves to be acknowledged, uplifted and celebrated around the world. It is a limitation that I do not provide a more fulsome account of this work. However, my intention is not to provide an in-depth (and

more balanced) account of histories of CHNs, but rather to highlight some uncomfortable truths about colonialism (past and present) in nursing that are often glossed over.

Nurses are complicit in upholding settler colonial and White supremacist systems through their inaction against systemic racism (Hantke et al., 2022; Stake-Doucet, 2020, 2023). Nurses also participated directly in establishing systems of European colonialism around the world (Bryder, 2018; Hawkins & Sweet, 2014; Krik, 2022b; Nestel, 1998; Rafferty & Solano, 2007; Sanders, 2024; Schuelke, 2017). However, nurses' roles in perpetuating colonialism are not well studied in Canada (Kelm, 1994; Schuelke, 2017; Symenuk et al., 2020). It is unsurprising that nursing, as a female dominated profession, is overlooked by historians of colonialism because, more generally, women's experiences of colonialism as both colonizers and colonized people (e.g., resistance among Indigenous women) are also complex and understudied (Albrecht, 2024; Loomba, 2015; Ware, 1992). Some White women within feminist movements in Europe, opposed and resisted colonial violence and advocated an end to colonial wars and/or to abolish slavery (Albrecht, 2024; Ware, 1992). Meanwhile, many White women actively participated in European colonialism around the world as nurses, teachers, nuns, and adoptive parents. White women interfered in Indigenous families lives (e.g., midwifery, birthing, infant care, child rearing practices) and disrupted intergenerational transmission of cultures to children that were taken from their families and placed under the direct care of settlers (Albrecht, 2024; Bryder, 2018; Dua et al., 2005; Hawkins & Sweet, 2014; Kelm, 1994; Krik, 2022a, 2022b; Nestel, 1998; Sanders, 2021, 2024; Schuelke, 2017). Nurses participated in the genocidal project of settler colonialism under the guise of angels.

Discursive Constructions of Nursing Angels

Women were called upon to serve the civilizing mission of settler colonialism as ‘mothers of the nation’ and ‘daughters of empire’ (Albrecht, 2024; Dua et al., 2005). Interestingly, nurses were not constructed as mothers and daughters for various reasons, and indeed a different social construction was required (Nestel, 1998). Purity and asexuality were paramount within the role of colonial nurse. Recruitment efforts for British nurses to serve in the colonies targeted single women aged 25-40, or so-called *spinsters*, and nurses had to resign if they wanted to marry and have children (Krik, 2022a). Therefore, nurses, as single women, “existed outside the usual space prescribed for colonial women as keepers of the imperial hearth and reproducers of the imperial race” (Nestel, 1998, p. 265). Christian churches were also extensively involved in colonialism (Albrecht, 2024; Kendi, 2016; Loomba, 2015; TRC, 2015). Many hospitals where nurses trained were faith-based and Christianity was (and still is) bound up with the profession of nursing; therefore, religious beliefs about certain behaviours (e.g., sexuality and substance use) informed nurses work (Hardill, 2007; Kelm, 1994; Martín-Moruno, 2020; Nestel, 1998; Sinha, 2017). Angelic images and white uniforms distanced colonial nurses from the taint of what European Christians perceived to be dirty and immoral about the Indigenous *Other* including “myths of native hypersexuality” (Nestel, 1998, p. 264). Therefore, the notion of nursing angels was socially constructed as a patriarchal tool to control nurses as well.

The discursive constructions of nurses as altruistic angels was rooted in colonialism and continues to be weaponized against both nurses and the people they aim to serve (Stokes-Parish et al., 2023). The ways in which nurses are discursively constructed as angels demonstrates some of the intersections between race, class and gender that both privilege and simultaneously oppress White women (Mendes et al., 2021). It is a patriarchal tool that hinders progress on

gender pay equity and safe working conditions for nurses, which became more apparent all around the world during the response to the Covid 19 pandemic (Mendes et al., 2021; Stokes-Parish et al., 2023). Gender pay equity and safe working conditions are issues among all nurses, but BIPOC women were disproportionately impacted by Covid 19 and harmful working conditions (Dailey et al., 2024). The narrative that nurses must be self-sacrificing and altruistic may also contribute to nursing shortages in Ontario, which is an important situational element influencing CHNs anti-oppression work.

Florence Nightingale's immortalized image of the *lady with the lamp* exemplifies the social construction of nurse as angel (Stake-Doucet, 2020). She also lived in Britain during the height of European imperialism and participated in colonialism (Sinha, 2017). Nightingale continues to be an influential and much celebrated nursing leader after her death. Her birthday on May 12th is marked annually around the world as International Nurses' Day (Brookes & Nuku, 2020). Shortly after her death, Eliza F. Pollard (1891) published a biography of Nightingale. In her book *Florence Nightingale The Wounded Soldiers Friend* there is appreciable evidence of the discursive constructions of nurses as angels. Also evident is the role of nurses in controlling social behaviours (i.e., vices) perceived to be immoral by European colonial worldviews.

> To write of one… whose living presence is so to speak, still hovering over us, is no easy task, and yet the simple beauty of Florence Nightingale's life minimizes the difficulty… because the work she had set herself to do lay in itself so near her heart, that… anything that might throw a slur upon it or call in question the purity of her motives, would have been pain and grief to her. She had a lesson to teach, which she… gave forth by precept and example to the world: the law of order and obedience, and the necessity of systematic

> training, by which alone knowledge and power can be acquired for the overcoming of vice and bringing of help and relief to suffering humanity. (Pollard, 1891 p. V1)

Despite her immortal angelic image, Nightingale is rightfully criticized by some people for her classist, racist, and sexist approach to nursing and failure to support feminist goals of the time such as women's suffrage (Brookes & Nuku, 2020; Stake-Doucet, 2020).

Undeniably, Nightingale wielded significant political power within Britain's war office and among politicians and academics (McDonald, 2011). She served as advisor to the governor of New Zealand between 1861 to 1868, this era involved brutal repression of anti-colonial uprisings among the Māori people (Brookes & Nuku, 2020). She worked as a nurse alongside British soldiers in colonial wars and also advised on health and social reform in colonial India (Sinha, 2017). Nightingale's influence was not limited to developing nursing theories and educating nursing professionals in Britain (Al-Chami et al., 2024). Moreover, the racism within her reports presented to the British colonial government, such as Nightingale's (1863) *Sanitary Statistics of Native Colonial Schools and Hospitals*, was not simply a benign product of her time. Nightingale's accomplishments are celebrated and implicitly accepted in nursing without critically engaging with this often forgotten history (Brookes & Nuku, 2020; Stake-Doucet, 2020). Gottlieb (2010) defensively claimed "when we undermine Nightingale we undermine nursing" (p.7) and praised one-sided accounts of Nightingale. Colonial harms of Nightingale's work are either ignored or are met with considerable defensiveness and outright denial (e.g., online vitriol to Stake-Doucet's critique of Nightingale's racism and Mcdonald's monitoring and defence to each Nightingale critique; Dillard-Wright, 2022).

Cultural Interference and Genocidal Acts

Nurses played a major role in colonialism worldwide (Bryder, 2018; Hawkins & Sweet, 2014; Krik, 2022b; Nestel, 1998; Rafferty & Solano, 2007; Schuelke, 2017). On a day-to-day basis, nurses in the community were, and still are, able to enter into private places, including people's homes. Therefore, CHNs had a key role in colonial interference into family life and social control over intimate spaces (Bryder, 2018; Hawkins & Sweet, 2014; Nestel, 1998; Rafferty & Solano, 2007; Sanders, 2024; Schuelke, 2017), and Indigenous children in Canada were removed from families and communities on the authoritative opinions of nurses (Kelm, 1994; Symenuk et al., 2020). State child apprehension in its many forms (e.g., residential school system, 60's scoop, modern child welfare systems) was, and still is, one of the most traumatic state interventions in the colonization of Canada (TRC, 2015). It is also part of Canada's history of genocide, although this is strongly denied by many Canadians.

The United Nations' (UN) definition of genocide is inclusive of forcibly transferring children from one group of people to another; therefore, the forced removal of Indigenous children from their families, subsequently placing them into the hands of the colonial state and transferring control over these children's lives to settler people is genocide (National Inquiry into Missing and Murdered Indigenous Women and Girls [MMIWG], 2019a). The forced sterilization of Indigenous women is also part of Canada's history of genocide (Clarke, 2021). The intention of these interventions were to eliminate Indigenous Peoples as a group with sovereignty and Territorial rights and to abolish their cultures, which is genocide even if the state did not attempt to physically kill all Indigenous Peoples in Canada (TRC, 2015; MMIWG, 2019). Canada's actions were different from other genocides involving systematic and direct lethal violence (e.g., firing squads, gas chambers). However, State policies were, and continue to be, knowingly

created that cause political precarity among Indigenous Nations and individual vulnerabilities (e.g., poverty). These policies, intentionally or not, ensure Indigenous Peoples will be exposed to violence that leads to death. Additionally, State actors and the settler public continuously turn a blind-eye to killings and disappearances of Indigenous Peoples (TRC, 2015; MMIWG, 2019).

Colonial Nursing Institutions and (Un)sanitary Statistics

Colonial schools and hospitals in British colonies around the world were segregated by race and designed as a tool of colonialism. White European women served the 'civilizing' mission of colonialism within these institutions as nurses and teachers (Bryder, 2018; Hawkins & Sweet, 2014; Kelm, 1994; Krik, 2022a, 2022b; Nestel, 1998; Pilon, 2008; Sanders, 2021, 2024; Symenuk et al., 2020). Nightingale assessed various British colonial social systems, and she documented her findings in a statistical report *Sanitary Statistics of Native Colonial Schools and Hospitals*, prepared for advisors in the colonial war office in Britain (Nightingale, 1863). Racism was evident in Nightingale's writings about Indigenous Peoples and alcohol use that persist in Canadian healthcare today. These racist narratives kill people (Government of British Columbia, 2020; Kamel, 2020; McCallum et al., 2021).

Nightingale (1863) collected data on mortality among Indigenous Peoples attending these schools and receiving hospital care. This data is meticulously presented in statistical tables divided by the various British colonies around the world and she specifically comments on the Canadian situation. Nightingale's (1863) data suggested that diseases such as smallpox, measles, TB and cholera caused the majority of Indigenous deaths that occurred in colonial schools and hospitals. The prevalence of specific pathogens varied by geographical location, for example she found that TB was the predominate cause of death in Canada. Nightingale (1863) attributed most of the diseases in schools to factors such as overcrowding, poor construction and ventilation of

schools, lack of physical exercise and outdoor work, and lack of vaccination. She noted that TB in Canada was related to the "native dwellings" and people closing off fresh air to maintain warmth in the cold climate (Nightingale, 1863 p. 8).

Although, her findings above are factors in transmission of these pathogens, she does not comment on how Europeans introduced many of these diseases, sometimes intentionally. Indeed she stated that "incivilization with its *inherent diseases* [emphasis added] when brought into contact with civilization without adopting specific precautions for preserving health will always carry with it a large increase in mortality" (Nightingale, 1863, p. 14), which seemed to suggest that these diseases were all present prior to contact with Europeans, but that these diseases became deadly when Indigenous carriers of the diseases were brought into contact with so called civilization (i.e., Europeans) without mitigation strategies. However, many of these diseases were introduced intentionally by European colonizers as warfare against Indigenous Peoples (Daschuk, 2013). Nightingale (1863) attributed excessively high hospital mortality in Canadian Indian Hospitals to "defective stamina in the population, delay in applying for medical relief, bad and insufficient hospital accommodation, or defective medical treatment and management of the sick" (p. 10). She did attribute some of the mortality to the hospital care itself, but it is telling, with the first two causes she lists, that she located the problem within Indigenous Peoples.

Nightingale also collected statistics related to alcohol use including liver disease and "diseases of the brain and nervous system" which she attributed to alcohol use (she didn't describe in the report the nature of these diseases or how they linked to alcohol use). In the Canadian "Indian" hospitals, she found that 6.5% of male admissions and 5.2 % of female admissions were due to brain and nervous diseases, and she found no reported liver disease. Despite her statistics clearly indicating TB as the principal cause of death, and not alcohol related

disease or STBBIs, she went on to suggest that alcohol use and "married women living in a state of prostitution" were the principal causes of declining Indigenous populations (Nightingale, 1863, p. 16). Statistics collected by the Canadian government during the first half of the 20th century also supported that TB continued to be the principle cause of death and that concerns about sexually transmitted diseases among Indigenous women were grossly overestimated by settler HCP and led to Indigenous women being "hunted down and forcibly confined" to protect nearby settlers and military personnel (Kelm, 1994, p. 60).

Nightingale noted that alcohol use among many British colonists was also problematic.

> The evidence contained in these notes unfortunately proves that the pioneers of British civilization are not always the best of the British people. Many of them, is to be feared, leave their own country, stained with vice and vicious habits… ready to take any advantage of the simplicity of the poor aborigines. (Nightingale, 1863, p. 15-16)

She passes moral judgments about alcohol use and oppressive actions among lower class British colonists, but not against the direct colonial violence ordered by the British war office, upper class military personnel, and politicians with whom she worked with and conversed regularly, which seemed to suggest that they were benevolent actors working in the best interests of Indigenous Peoples around the world. Her compassion expressed in written communications may have been more a tactic to exert agency as a woman in male-dominated spheres than an authentic emotional response to suffering among Indigenous Peoples (Martín-Moruno, 2020).

Moreover, she highlighted high mortality in schools, but then she contradictorily suggested that "in as far as concerns the effect of the schools on the disappearance of native races, the returns contain no appreciable evidence" (Nightingale, 1863, p. 14). She described that the benefits of civilizing future generations outweighed the risks of morbidity and mortality.

Additionally, despite dedicating an entire chapter to the importance of nutrition in her *Notes on Nursing* (1860), she omitted any critique in her report on colonial schools and hospitals of the poor nutrition provided to Indigenous children. To her credit Nightingale (1863) did argue that education should be more gradual and with less interference to Indigenous habits and customs. She highlighted that schooling in Britain was not the best model to replicate because it also had deficiencies and negative impacts on students, but did not have the dire consequences of high mortality among British students compared to Indigenous children in colonial schools.

Nightingale (1863) acknowledged that without colonial interference Indigenous populations would not decline, but she did not advocate withdrawing British colonists from Indigenous lands around the world. Instead, she recommended the following: the provision of land, but only on the condition of Christian conversion. She argued "that provision of land should be made for the exclusive use of the existing tribes; but this, by itself, would be simply preserving their barbarism for the sake of preserving their lives" and that they be required to live in settlements "under whatever Christian denomination… for the purpose of wisely and gradually winning the people to higher and better habits" (Nightingale, 1863, p. 16-17). She also advocated for attention to sanitation, clean water and overcrowding, but she did not suggest that people be permitted to live on the land outside of British controlled Christian settlements where for millennia they have enjoyed clean water and sufficient space to avoid the diseases that she also noted could be attributed to poor sanitation and overcrowding so prevalent at the time in impoverished parts of British cities. She advocated continued use of colonial schools even while she acknowledged that although a "large proportion of children have died while under school instruction, there is no proof that education, if properly conducted, tends to extinguish races" (Nightingale, 1863, p.17). She recommended alcohol prohibition among Indigenous Peoples, but

not among colonists. She explicitly called for “state interference” by Britain in the form of paternalistic control (Nightingale, 1863, p. 18).

Nightingale concluded her report by quoting “on account of its authority” (1863, p. 18) the Legislative Council of Victoria in 1858-1859 that “[t]he great cause [of declining Indigenous populations], however, is apparently the inveterate propensity of the race to excessive indulgence in spirits, which it seems utterly impossible to eradicate. This vice is not only fatal, but leads to other causes which tend to shorten life” (Perres, 1859, p. iii). Nightingale upheld the claims of the Legislative Council of Victoria and made conclusions about alcohol and prostitution despite her own data, which was contradictorily pointing to infectious diseases that are not sexually transmitted such as TB and measles. Her findings clearly perpetuated anti-Indigenous stereotypes about alcohol and other so-called vices (e.g., sexuality). Her perspectives have continuities with current stigmas and stereotypes that all nurses must fight against. These stigmas and stereotypes are particularly relevant to CHNs in harm reduction. Nightingale’s (1863) Report advocated for continued colonial incursions and interventions in Indigenous societies (e.g., the continuation of residential schools and land theft) that led to death, disease, intergenerational trauma and loss of culture, devalued traditional healing, and restricted Indigenous access to engage in healthy lifeways (RCAP, 1996; TRC, 2015).

Colonial Nursing Interventions Into The Present Day

Not surprisingly, settler nurses, as key HCPs, were extensively involved in colonial healthcare institutions such as Indian hospitals and TB sanitoriums. Patients were subject to violence and abuse in these institutions, similar to residential schools (Drees, 2013; Kelm, 1994; Lux, 2016). Harms of medical/healthcare institutions are documented in excellent Indigenous films (e.g., *Martha of the North* (Lepage & Flaherty, 2009); *The Necessities of Life* (Pilon,

2008)), even if nurse researchers have paid scant attention to this history (Symenuk et al., 2020). Nurses participated along-side the Royal Canadian Mounted Police (RCMP) in the forced removal of Indigenous Peoples from their home communities for medical treatment (Kelm, 1994; Symenuk et al., 2020). Many people never returned home resulting in unresolved grief for many families (Moffatt et al., 2013). Nurses and their Indigenous patients sometimes spent long periods of time (weeks/months) on hospital ships that traveled to Inuit communities in remote Arctic regions (Lepage & Flaherty, 2009). Children were forced to leave their communities without their parents for medical treatments, and some children were never returned to their parents (Lepage & Flaherty, 2009; Pilon, 2008). Indigenous Peoples' forced treatment in TB sanitoriums continued even after the advent of effective TB medications that allowed White people to be safely treated at home; furthermore, Indigenous people in the north continue to experience high rates of TB (Orr, 2013; Public Health Agency of Canada, 2013). During my time in Yellowknife (2006-2012), I became acutely aware of the mistrust that some Indigenous people had towards HCPs and the treatment decisions that HCPs made. I cared for many patients on isolation precautions for TB and yet I was unaware of this history. Therefore I did not fully understand the origins of people's mistrust. We did not have in-service education on this history, despite the importance of this knowledge to provide culturally safe and trauma informed care in northern nursing settings, which should be part of mandatory orientation sessions.

Nurses were also actively involved in controlling Indigenous families' reproduction (e.g., forced sterilization), child rearing (e.g., residential schools), and eliminating their lifeways and healing practices (e.g., Indigenous midwifery). Nurses, past and present, have participated in sterilization of Indigenous women through coercive means or assisted physicians to perform the procedure without women's knowledge and consent (Boyer & Leggett, 2022; Clarke, 2021). As

noted previously, nurses participated in residential schools and Canada's long history of state child apprehension. Nurses also forced women to travel for hospital child births; and even today many Indigenous women from remote communities spend a month or more away from their families while waiting to go into labor, which eliminates important opportunities to celebrate life within Indigenous communities (Cidro et al., 2020; Moffitt & Robinson Vollman, 2006; Silver et al., 2022). Medical travel to access physicians and acute care hospitals remains common practice in rural and remote communities, although it may at times be requisite to access more specialized healthcare. I have witnessed first-hand in both Yellowknife and Ottawa the myriad of ways medical travel continues to cause harms (e.g., isolating people from their families and supports for major life events including birth, death and illness and as a pathway into homelessness).

Nurses' roles in colonialism (described above) may not seem immediately relevant to urban CHNs' day-to-day work in harm reduction. Therefore, I highlight a few ways the previous sections connect with substance use policies described at the start of this chapter and Indigenous homelessness. In many ways, colonial nurses were an extension of repressive arms of the colonial state and were tasked with controlling intimate spaces, cultural practices, and determined the morality (based on European Christian beliefs) of behaviours within Indigenous communities and cultures. Nurses were constructed as virtuous angels and served as a tool for social control in colonialism and they continue to participate in controlling so-called vices (e.g., substance use and sexual practices). CHNs, past and present, entered into families' homes as part of their nursing practice. The ways in which substance use policies (including alcohol prohibitions) could have been enforced by CHNs and used to further colonization are particularly relevant to this thesis, although this is not well documented. Prohibitionist alcohol policies might thus have been used by CHNs within their home visiting practices in colonial settings to

facilitate state child apprehension. Arguably, breaking the law by having illicit substances in the house would be considered by many service providers to be indictive of poor parenting (Denison et al., 2014; Jongbloed et al., 2024; Ritland et al., 2021).

Nurses and other HCPs continue to participate in state child apprehension and report Indigenous families to the relevant authorities when they perceive that parenting does not meet settler standards (Denison et al., 2014; Roxburgh & Sinclair, 2024). For example, overcrowded housing, substance use and other street involved behaviours such as sex work are all used as rational to remove children from the home regardless of whether the child is endangered by these poverty related issues (Roxburgh & Sinclair, 2024; Stefanick & Tait, 2024). Indigenous women and families continue to suffer disproportionate rates of child apprehension compared to White settler counterparts and this disparity is not solely attributed to poverty—racial biases among settler child welfare authorities are also to blame (Blackstock, 2019; Roxburgh & Sinclair, 2024; Stefanick & Tait, 2024). These inequitable child welfare practices are associated with wide ranging health impacts including, deterred access to healthcare among mothers (Denison et al., 2014) and a sense of hopelessness that contributed to suicide and lower adherence to HIV treatment (Jongbloed et al., 2024; Ritland et al., 2021; Stefanick & Tait, 2024).

According to point-in-time counts from the City of Ottawa (2021), 43% of Indigenous respondents had been in the child welfare system and 14% of Indigenous youth became homeless within one day of aging out of care[4]. Additionally, state child apprehension has been linked to homelessness among Inuit women who travel to urban centers to be closer to their children who

[4] Currently in Ontario, youth are required to leave child welfare placements when they turn 18 years of age with some transitional supports offered until 21years of age. Prior to January 1, 2018, youth were ineligible for the full range of child welfare services when they turned 16 years of age and placements remain voluntary for youth ages 16-17 years of age Government of Ontario. (2021). *Protection services for 16 and 17 year olds*. Retrieved from https:www.ontario.ca/files/2022-04/mccss-information-for-you-serving-agencies-en-2022-04.pdf.

are placed in foster care in urban centers (e.g., Ottawa) far from home (Pauktuutit Inuit Women of Canada, 2017). Increased stress from trying to navigate child welfare systems also resulted in substance use relapses among women that were abstinent (Jongbloed et al., 2024; Ritland et al., 2021; Stefanick & Tait, 2024), which may also contribute to Indigenous homelessness.

Shifting Notions About Racism

As we move from historical descriptions of nurses' racisms into today, we must note that our understandings of what racism is and how it operates has also shifted dramatically since the term first emerged into our vocabulary. Bonilla-Silva (1994) argued that most conceptualizations of racism described the concept as behaviours based on (irrational) ideas and beliefs and that this theory of racism is built on Ruth Benedicts first use of the term in 1942. Arguably, the general public still predominantly perceive that racism is overtly bad behaviours and beliefs enacted by individuals; nevertheless, the notion of systemic racism is gaining some ground. Many scholars agreed that we need to shift our focus away from the notion that we can eliminate racism by rooting out the "bad apples" and towards understanding and dismantling racialized systems (Bonilla-Silva, 2021; Collier-Sewell, 2023; Kendi, 2016, 2019). Moreover, nurses must gain better theoretical understandings of colonial systems and structures to address the multiple and intersecting oppressions that work against themselves as nurses and the people they aim to serve.

Systemic Racism and Racist Policies

Systemic racism is a central concept in this thesis and I draw on Bonilla-Silva's work (1994, 2021, 2023) to describe it. Bonilla-Silva has argued that, "rather than viewing racism as a mere idea, belief or attitude, I contend that racism is the ideological apparatus of a racialized social system" (Bonilla-Silva, 1994, p. 2). Furthermore, when "racism is conceived of as a belief with no real social basis, then it follows that those who hold to racist views must be irrational

and/or stupid. This … misses the very rational elements upon which racialized systems were originally built … it neglects the possibility that contemporary racism still has a rational foundation" (Bonilla-Silva, 1994, p. 8). In other words, if racism is primarily an irrational belief and if structures that functioned as intended must be rational, then systems could not be racist. Moreover, present day systems are described as broken rather than acknowledge that they continue to function as they were historically intended. Ongoing harms described earlier, illustrate the outcomes and intent behind racist and violent systems that were designed to assimilate and segregate Indigenous Peoples.

Bonilla-Silva described social systems as relationships between people that are characterized by shared social norms and behaviors that people will generally follow. The system is reproduced when people interact with each other. Racialization emerged with the creation of hierarchal racial categories by Europeans. Importantly, races are also social collectives (e.g., based in geographical origins, cultures, religious values) and collective social interests may conflict and compete along racial lines contributing to racial struggles. Collective social interests also conflict along gender and class lines contributing to gender/class struggles both within and across racial groups (Bonilla-Silva, 1994, 2021, 2023). Kendi (2016, 2019) has argued that racism was (and still is) about self-interest and power, not ignorance. Racist ideas were created to justify ongoing exploitation of other human beings (Kendi, 2016, 2019).

A systemic or structural conceptualization of the problem points to eliminating the systemic roots as the cure for racism (Bonilla-Silva, 1994, 2021, 2023; Kendi, 2016, 2019). Additionally, conceptualizing underlying structures as racist suggests that systemic changes are requisite to eliminating negative stereotypes. Bonilla-Silva claimed that "stereotypes are reproduced because they reflect the distinct real position and status of the group in the racialized

system. As a corollary, racial or ethnic notions about a group disappear only when the status of the group mirrors that of the dominant racial or ethnic group in that society" (Bonilla-Silva, 2023, p. 35); therefore, one could argue eliminating Indigenous homelessness would be requisite to eliminating racist stereotypes. Furthermore, White people are treated as individuals while everyone else is seen as representative of their racial group (Kendi, 2019; Frankenberg, 1988). For example, substance use among White people may still be stigmatized and seen as a moral failure or rooted in social class, but no one would suggest that substance use among White people is due to their race. This contrasts sharply with stereotypes about Indigenous Peoples and false beliefs about innate susceptibilities to alcohol such as those perpetuated in Nightingale's (1863) report.

Kendi (2019) has noted preference for the term "racist policy" over "systemic racism," suggesting that systemic racism is a confusing term that often conflates racist policies (which it is) with widespread prejudicial beliefs or overt racist behaviours among the vast majority of employees within a system (which is not always the case). I agree with Kendi (2019) that racist policy is conceptually simpler, but I also argue that systemic racism is a necessary and accurate term that is critical for nursing research into health disparities. Systemic racism draws our attention from the policy itself towards also looking at the ways in which White settler people, including nurses, uphold racist policies, systems and structures and perpetuate racial inequities. The denial of systemic racism is one of the many ways that White supremacist systems are upheld (Bonilla-Silva, 2021; DiAngelo, 2018). Similarly, White settler denial of colonial harms and White silence are problematic racial behaviours that uphold colonialism. Nurses must overcome their tendencies towards silence, which upholds White privilege and is reflective of colonial and patriarchal expectations of women and is problematic within nursing as a female

dominated profession (Bell, 2024; Collier-Sewell, 2023).

Whiteness is Not Simply a Skin Color

Whiteness is a standpoint through which White people view the world (Frankenberg, 1988) and exposing White racial beliefs and behaviours is critical to dismantle systemic racism. In the following section, I theoretically explore White racial behaviours that uphold settler colonialism in Canada. Structures are socially constructed but are often conceptualized as an empty shell that operates independently of the actors within them. Structures are essentially synonymous with systems. They are both made up of networks of people and the practices they follow based on social norms and the policies that they create (Bonilla-Silva, 1994, 2021, 2023). Therefore, reproducing systemic racism "depends fundamentally on behaviors and actions that are normative, habituated, and often unconscious" (Bonilla-Silva, 2021, p. 513). In other words, maintaining structures/systems upholds systemic racism even if individuals are not engaging in overtly racist behaviors.

White Habitus. Bonilla-Silva described that White habitus "generates practices, cognitions, perceptions, and emotions that reinforce whiteness and account for Whites' racial isolation. Once Whites are charged in the white habitus, it is quite difficult for them to cross racial lines" (2021, p. 517). The concept of White habitus generates understanding of how White people perceive their worlds and maintain their White racial privileges. "Once a racial system roots, we all become habituated by its norms, culture, and collective practices", habits may be only partly conscious, but are typically not fully unconscious; moreover, White people may be more conscious of their racial habits than they let on (Bonilla-Silva, 2021, p. 519).

White Benevolence and White Saviorism. Canadians' White habitus revolves around constructing themselves as benevolent, and more tolerant than people in the US, which would

seem to be incongruent with racism, ignorance, and hate. Despite this supposed multicultural embrace, Canadians may be no more likely than their US counterparts to 'cross racial lines' in their everyday lives. For example, Canada has a long history of policies of forced segregation of Indigenous Peoples (e.g., reserves and pass systems) onto rural or remote areas that were seen by the government as less desirable settlement areas, which cleared the way for settlers to take over land stolen from Indigenous Peoples (RCAP, 1996). Investments into infrastructure in these areas are typically not prioritized by provincial or federal governments; therefore, many Indigenous communities remain geographically distanced from places where White people live. Segregation also continues in urban areas as a result of neighborhood wealth disparities. Canada has evaded Western critique of its anti-Indigenous policies and denied systemic White supremacy through constructing itself as benevolent and a multicultural state (Jewell & Mosby, 2022, 2023).

Awareness among settler Canadians of the historical violence against Indigenous Peoples has increased in the last 10 years due, in part, through the important work of the TRC. There were also numerous government reports and evidence put forth by Indigenous groups prior to the TRC that were unfortunately ignored by politicians and the general public (e.g., Bryce, 1907; Bryce, 1922; RCAP, 1996). Despite a growing awareness, Canadians' White benevolence is unlikely to subside, although they may declare their White guilt accordingly. White benevolence will likely continue because settler Canadians still predominately view Indigenous Peoples through a deficit-based lens, which may now be informed by their increasing knowledge of intergenerational trauma. When Indigenous Peoples are viewed solely through the lens of trauma then the overtly negative stereotypes might decrease and compassion may increase, but it also easily slides into White saviorism and paternalistic racism (Gebhard et al., 2022). Indeed, the perception that Indigenous Peoples are damaged and broken by colonization may be weaponized

against them to deny their rights to self-determination and belittle their resistance efforts as ill-informed rebellion (Andersen & Walter, 2013; Tuck & Yang, 2014). White saviorism suggests that White people are uniquely positioned to solve Indigenous Peoples' problems and that Indigenous Peoples are incapable of taking care of themselves. It minimizes their strengths, resiliency and leadership. Paternalistic racism and White benevolence are key ways that settlers maintain their racial advantages over Indigenous Peoples. White benevolence also manifests at individual levels and is particularly problematic in the helping professions (Gebhard et al., 2022; Nath & Allen, 2022; Nestel, 1998).

Racially Coded Language and Implicit Bias. Implicit bias and the use of racially coded language are also problems in healthcare. For example, a US study by Boley et al. (2024) analyzed HCP notes (N=45,591) for use of both positive and stigmatizing language in emergency dept (ED) charts. They found that Native American (i.e., Indigenous) patients had the highest prevalence of four out of five stigmatizing themes in their charts including: *difficult*, *non-compliant*, *substance abuse/seeking*, and *financial difficulty*, with 81.2% of notes in Indigenous patients' charts containing the presence of at least one stigmatizing theme. The statistical rates for the presence of stigmatizing themes for Indigenous patients was higher than for all other patient groups in the study including Black, Hispanic, and White patients (Boley et al., 2024).

News media articles, and politicians and members of the publics' comments within them, are also more likely to use racially coded language than overt racism. For example, researchers suggested that in media coverage of the homelessness and overdose crises terms such as inner city, poor, and 'street addict' were bound up with racist and classist connotations; meanwhile, middle class, employed, suburban, young, and innocent victims were racially coded terms for White (Dertadian & Rance, 2023; Fraser et al., 2018; Johnston, 2020). Even when media did

present stories of harm and photos of Indigenous girls and other young BIPOC peoples, their youthful innocence was denied. This phenomenon of denying innocence among Indigenous youth was noted both in stories about the overdose crisis and murdered and missing Indigenous women and girls in Canada (Gilchrist, 2010; Johnston, 2020; MacCandless, 2013).

Media discourses influence policy making and media's use of racially coded language are further evidence of the ways in which race neutral policies may actually be racist in intent and outcome. An example of racist mediatized health policy-making is the "Stop Overdose" campaign developed by the BC government. Studies revealed the official anti-stigma campaign strategy was to distance less stigmatized users (e.g., suburban youth, employed middle-class adults) from the overwhelming stigma of *street addicts*. The campaign (re)presented images of what they perceived to be more sympathetic victims among the general public that could be your coworker (employed), neighbor next door (White suburbia), or child (innocent) and ignored the substance use stigmas faced by Indigenous Peoples and other people living in poverty and/or homelessness (Greto, 2023; Greto & Neufeld, 2024). Studies in New Zealand and Australia have shown that circulating discourses about Indigenous Peoples in the media were connected to backlash politics and paternalistic policy making (Baker et al., 2018; McCallum, 2013; McCallum & Waller, 2017), and also impacted cultural safety among HCPs (Nairn et al., 2011; Nairn et al., 2014). Media discourses are key situational elements in this study because of media influences on policy making in the interconnected realms of healthcare, harm reduction, and Indigenous homelessness. Therefore, media discourses that perpetuate backlash against people who are homeless or use drugs have a direct impact on CHNs anti-oppressive work. Additionally, media are influential in shaping public perceptions, and therefore, media discourses may influence CHNs' understandings of Indigenous issues (Nairn et al., 2011; Nairn et al., 2014).

Exploring Contemporary Racism in Healthcare

Racially coded language, White benevolence, White saviorism, and silence may be more insidious and subtle forms of racism (or at least go unnoticed by other White people), but overtly racist behaviours are still a problem in nursing as evidenced by the comments captured in Joyce Eschequan's live stream video on social media. Moreover, many nurses may not openly make such overtly racist comments, but nonetheless habitually and subconsciously engage in moral judgments and make deadly assumptions about Indigenous Peoples and substance use. I return to the story of Joyce Eschequan, although I acknowledge that there are many other examples of systemic racism in Canadian healthcare. Joyce's story was highly publicized, and therefore it provides a rare glimpse into some of the sociopolitical responses when racism in healthcare is publicly exposed. It also offers a look into the circulating discourses about systemic racism in mainstream media. Sociopolitical responses to racism are important elements to this situational analysis and illustrate issues relevant to CHNs anti-colonial struggles.

A Few Bad Apples

In the wake of Joyce Eschequan's death, narratives emerged in media and political arenas that denied the problem of systemic racism in healthcare and instead focused on blaming a few bad apples. Joyce's death, like so many Indigenous deaths before and since, was tragic and avoidable. Her actions were also an incredible act of resistance against White Supremacy. The media and political discourses surrounding her death revealed how systemic racism was denied in favor of individualized notions of racism. The horrendous behaviours of nurses in Joyce's video sparked public outcry and the long overdue development of a principle to address anti-Indigenous racism in healthcare. Joyce's Principle, as it is called, "aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and

health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health" (Council of the Atikamekw of Manawan & Council de la Nation Atikamekw, 2020). In November of 2020, Joyce's Principle was rejected by the Quebec government because of the term "systemic racism" and their denial that systemic racism exists in Quebec.

Premier Francois Legault referenced Quebec's anti-racism task force as the government's action strategy (Richardson, 2020). The task force, which lacked Indigenous oversight, consisted of 7 Members of the National Assembly (MNAs), none of whom were Indigenous. When asked why there was no Indigenous representation, Legault replied because there are no Indigenous MNAs in his Coalition Avenir Québec political party (Luft, 2020; Richardson, 2020). Legault's response suggested that political affiliation was more important than Indigenous representation and led to the exclusion of Indigenous Peoples' lived expertise of anti-Indigenous racism within the task force. This response also highlighted the exclusion of Indigenous Peoples from Quebec's provincial politics, which in itself is indicative of systemic racism. Nursing does not exist in isolation from the broader dominant culture in settler society—to be sure, systemic racism does exist in Quebec and all other Canadian provinces and territories (MMIWG, 2019b; Phillips-Beck et al., 2020; TRC, 2015; Viens, 2019). Settler denials of systemic racism importantly requires nurses to think deeply about their role in upholding colonial systems.

The denial of systemic racism put forth the few bad apples defense, while a predominately White anti-racism task force allowed for these narratives to go unchecked. The few bad apples narrative is also commonly found in nursing discourses and is further perpetuated by nursing research that solely presents horrific stories of harm (Browne et al., 2023; Gebhard et al., 2022). This discourse goes something like this: Racist individuals are simply a few bad apples that openly say overtly racist and hurtful comments and engage in overtly racist and

harmful behaviours; therefore, the system is not the problem, but rather racism is a problem among a select few individuals (Bonilla-Silva, 2021, 2023). The solution to individualized notions of racism suggests that those "bad apples" (i.e., individual racists) can be rooted out and fired or required to attend a course that will enlighten them to their ignorance. This is also the basic premise of "zero-tolerance" anti-racism policies. However, the solution to systemic racism requires changes to social systems and an acknowledgment that social structures are premised on White supremacy (Bonilla-Silva, 2021, 2023). This acknowledgment tends to trigger a lot of defensiveness among many White people who deny that their socioeconomic advantage occurs as a direct result of racist social systems, such as settler colonialism. Individualism and meritocracy suggest that socioeconomic advantages occur solely as a result of hard work and strength of character. Oftentimes, politicians and their White settler constituents also tend to dislike the prospect of more intensive, expensive, and disruptive changes that are requisite to tackle racial inequities (Grey & James, 2016; Jewell & Mosby, 2022, 2023).

Unfortunately, the death of Joyce Eschequan was not an isolated incident, but it was unique in that it was caught on camera and received national media attention. The death of Brian Sinclair in 2008 is yet another high-profile example of how fatal these common narratives about Indigenous Peoples and substance use can be. Brian Sinclair, a First Nations man and double amputee in a wheelchair, was literally ignored to death in a hospital (Preston, 2014). He was presumed by the triage nurses to be simply drunk and sleeping it off or already discharged and homeless with no other place to go. After waiting over 34 hours to be seen in a Winnipeg emergency room, he died of a treatable bladder infection (Preston, 2014). Notably, he also had contact with community healthcare and was sent to the ED by CHNs and other HCPs, which

exemplifies some of the systemic challenges and disconnect between community healthcare and acute care (McCallum et al., 2021).

Doctors represented at the time by Dr. Jill McEwen, president of the Canadian Association of Emergency Physicians, criticized the inquest's lack of attention to inpatient bed shortages as the driving force behind ED overcrowding, which was deemed a primary cause of Brian Sinclair's death (CBC News, 2015). Meanwhile, Indigenous groups and Brian Sinclair's family called for the scope of the 2014 inquest to be expanded into examining the problem of systemic anti-Indigenous racisms and argued that stereotypes about Indigenous Peoples and substance use were the principal cause of Sinclair's death. Dr. Thambiraja Balachandra, Chief Medical Examiner of Manitoba, testified at the inquest "If Snow White had gone there, she would have got the same treatment under the same circumstances… Brian Sinclair or Snow White—it's the same" (McCallum et al., 2021, para 1). The chief medical examiner in essence denied the existence of systemic racism in Manitoba healthcare. Moreover, without overt racism caught on camera, the medical examiner denied entirely that racism (in any form) had occurred. The inquest findings didn't acknowledge that racism may have played a role on an individual level when nurses ignored Brian Sinclair on the basis of stereotypes that he was "sleeping it off" or homeless. Importantly, the few bad apples narrative feeds into insidious discursive constructions of nurses as angels that are self-sacrificing and can do no harm. If most nurses are angels, then racism cannot be rooted in the nursing discipline itself. Nurses caught acting racist are simply a few bad apples among the overwhelming majority of nurses whom are angelic, morally good, and altruistic.

Additionally, current staffing crises, bed shortages and overcrowding may be even more acute in Ontario's post-pandemic healthcare than at the time of Brian Sinclair's death in 2008,

and are likely to impede the development and implementation of mandatory anti-racism/cultural safety training for practicing nurses. Ontario RNs have considerable time and funding constraints and are working short-staffed (Denley, 2024). The issue is even more acute in remote Indigenous communities (Martens, 2024). Burnout among nurses and the staffing crises may exacerbate stigma and discrimination in healthcare as nurses may express greater frustration with people whom they perceive to be less deserving of care or burdening an already overstretched system. People experiencing homelessness and substance use are generally perceived to be less deserving of care (Van Boekel et al., 2013). Therefore, nursing shortages significantly impact CHNs' advocacy work with people marginalized by substance use and homelessness to ensure they have appropriate access to health care where and when they need it.

Racist Moral Judgments and Ethical Transgressions

Joyce sought witnesses, through her use of social media, to anti-Indigenous racism when she filmed the racist and ultimately fatal nursing care she received before she died. In Joyce's story, we see that she suffered extreme dehumanization by the nurses tasked with her care. Alone in the hospital the presence of an addressable other was severely limited, which worked to undermine her subjectivity and agency in traumatic and horrific ways. Yet, Joyce's story is also suggestive of resistance and a demand for what Oliver (2000) described in her theory of witnessing as addressability and response-ability. The act of bearing witness relates to our ability to respond to that which we may not be able to see or comprehend (i.e., unable to recognize), and our ethical responsibility to the address and response with another (Oliver, 2000, 2001). It is through our own addressability and response-ability with another human that we develop an inner witness to whom we address our lives. The violence inflicted on Joyce cut off her ability to address her nurses about her imminent and life-threatening concerns and the nurses failed to

respond to her precarious situation with ethical care, compassion, and ultimately withheld timely interventions requisite to keep her alive.

The concept of a testimonial network, defined as a "circulatory system within which life story and testimony encounter conflicting ideologies, politics, and judgments as they move in search of a hearing" (Gilmore, 2017, p. 60), may be helpful to explain elements of Joyce's story. Testimonial networks may also be useful to understand the role of electronic medical records (EMRs) in systemic racism. Racist assumptions and judgments are perpetuated and reinforced among HCPs in multiple professions. HCP's documentations in EMRs facilitates the spread of moral judgments and false assumptions allowing them to quickly travel from one HCP to the next, across multiple visits and different healthcare locations. Therefore, EMRs are part of racist systems and structures (Boley et al., 2024). They are also documented evidence of ethical transgressions, as the coroner's inquest into Joyce Eschequan's death so clearly illustrated.

Gilmore described the ways in which testimony travels through testimonial networks in search of an adequate witness, which was exemplified by Joyce's use of social media and her livestream broadcast of nurses' racist behaviours. Joyce's inner witness may, or may not, have been restored through her use of social media in the moments before she died; however, clearly her testimony continued to travel and reverberate post-mortem in search of witnesses and redress. Importantly, Joyce's testimony demands that nurses engage in anti-colonial struggles and heed Joyce's call for an addressable and response-able other.

Responses, including empathy and judgments from others (e.g., nurses or consumers of mainstream media), also form part of the testimonial network and influence how knowledge is produced and the spaces in which stories are heard. Judgements may be a necessary part of ethics, politics, testimony and witnessing; however, judgements such as those violently inflicted

on Joyce may also be based on prejudice, stereotypes, and stigma. “Truth-telling is negotiated around and between the performance of a story and the power imbalances of the space in which the story is listened to” (Marker, 2009, p. 30). Nursing care necessarily involves eliciting narrative stories from clients/patients about their lived experiences of health and wellness that brought them to seek care. Nurses seek information to guide assessments and inform nursing care. They then document this information in EMRs. For example, nurses ask patients to describe their pain and may judge these narratives as truthful or not (i.e., drug seeking) before providing pain medication and empathy. Producing testimonial knowledge is also important to social justice and human rights work. Stories may be powerful tools to evoke feeling and promote advocacy, political action, and social change; however, this power travels along clearly defined pathways that privileges the testimony of some people over others (Gilmore, 2017).

Judith Butler (2009) argued that we must not conflate ethics with making moral judgments. Moral judgement presumes moral norms can be universally applied despite cultural differences. Judgement may also distance oneself both relationally and morally from the person being judged. Despite ethical judgements being requisite to “political, legal and personal life alike” she argued that only through suspending judgment “do we finally become capable of an ethical reflection on the humanity of the other” (Butler, 2009, p. 45). When ethical judgments are necessary, ethical relations between ourselves and those we may judge are critical. Butler (2009) described that judgment is a mode of address, the ethical value of which “is conditioned by the form of address it takes” (p.46). She suggested condemnation is a form of moral judgment that often seeks to inflict violence on others perceived as different from ourselves. Furthermore, “the structure of address conditions the making of judgments about someone or [their] actions… and

that the judgment, [when] unbeholden to the ethics implied by the structure of address, tends toward violence" (Butler, 2009, p. 62).

The unethical judgments reflected in the nurses' comments to Joyce amounted to racist moral condemnation rooted in White supremacy. According to the coroner's report into Joyce's death, a nurse was recorded saying, "Well, you made some bad choices, baby. What would your children think, seeing you like this?" (Kamel, 2020, p. 11) and after her death a witness reported that they heard a nurse say "Indian women like to complain about nothing, to get stuffed and have children. And it's us who pay for it. At last she is dead" (Kamel, 2020, p. 13). The inaccurate assumptions about Joyce's behaviours reflected racial prejudice about Indigenous Peoples and alcohol use, Indigenous women as promiscuous and bad mothers, and us (White, settler taxpayer) versus them (Indigenous Peoples) discourses are also apparent. These racist assumptions contributed to Joyce's suffering, and ultimately led to her death (Kamel, 2020).

Gilmore (2017) described how empathy and judgment travel along predictable pathways within testimonial networks and are highly influenced by the gender and race of the witness recounting their story of harm. She argued that some people (e.g., Black or Indigenous women) often become tainted witnesses as a direct result of intersecting oppressions. Unfair or inaccurate judgements follow and stick to tainted witnesses, regardless of what they say or do. Gilmore's analysis may be useful to illuminate how nurses come to deem some people's claims regarding their pain, suffering, and/or other symptoms to be legitimate, while other people's claims are demeaned by nurses. Unfortunately, negative judgments documented by HCPs in EMRs may stick throughout ones' healthcare trajectory and follow persons throughout their hospital stay and from one hospital visit to the next. For example, a physician documented in Joyce Eschequan's chart that she was "theatrical" and "has a tendency to manipulate" (Kamel, 2020, p. 8).

Judgments such as these can lead to misdiagnosis, inappropriate treatment, culturally unsafe nursing care, and even death. In the case of Joyce Eschequan, it was repeatedly documented by HCPs that she was having symptoms of drug and alcohol withdrawal despite a lack of evidence to support this diagnosis. She was also erroneously labeled as a "narcotics addict and, based on this prejudice, her calls for help were unfortunately not taken seriously" (Kamel, 2020, p. 8). This misdiagnosis of drug and alcohol withdrawal was further confirmed to be false by postmortem toxicology reports (Kamel, 2020).

The coroners' report on Joyce Eschequan's death shed some light on how other people in similar social positions may be treated in acute care and the documentation in charts that can lead to them becoming a tainted witness. Moreover, the concept of a tainted witness is useful to explore how nurses respond to some people's stories with racism and negative judgements rather than empathy. Empathy is seeing the world as others see it in an attempt to understand another's feelings, and must be communicated to be felt by another (Wiseman, 1996). However, empathy has been criticized because it relies on sameness, and identification with shared experiences, and therefore may contribute to discrimination. Lather suggested that, "to argue against empathy is to trouble the possibilities of understanding as premised on structures that all people share" (2009, p. 19). Unconditional compassion must not rely on one's ability to empathize with others' experiences. We are all situated differently in relation to social structures, in other words, we do not share the same subject position. Privilege and oppression are relational and often impair one's ability to empathize across differently situated subject positions and witnesses become tainted as a result of their social position. This further supports Oliver's arguments that witnessing, rather than recognition, should ground our ethical frameworks within social institutions and relationships. Witnessing may therefore be an ethical approach for nurses'

responses to suffering and harm. I now turn from describing racism and colonialism in nursing more generally, towards exploring and understanding the social world of harm reduction. This exploration of harm reduction is critical to situate CHNs anti-colonial struggles into current sociopolitical environments in Ontario and Canada more broadly.

(un)Ethical Approaches to Homelessness and Harm

Although harm reduction is an inherently ethical approach for nurses' anti-oppressive work, it is not without critiques. A conservative backlash against harm reduction is quickly gaining traction (Michaud et al., 2024), but there are also criticisms from within the social world of harm reduction. I argue that there are many parallels between settler backlash against anti-racism efforts and the current conservative backlash against harm reduction and other ethical approaches to the homelessness crisis. Additionally, I suggest that many of the critiques from within the social world of harm reduction relate to the ways in which nursing has maintained continuities with their colonial histories. I begin with a discussion of academic literature on harm reduction philosophies and critiques before exploring conservative harm reduction backlash through analysis of media articles and political statements.

Overview of Harm Reduction Philosophies and Critiques

Origins of harm reduction as a grassroots movement are inherently rooted in political activism and historically focused on structural changes and challenging harmful drug policies. Cross, (2017) a social work scholar and harm reduction worker described, as a queer person living with HIV, that he defines harm reduction "the way that it is practiced within my community as a deeply political form of mutual aid and collective care, as well as a creative strategy to resist heteronormativity" (p. 2-3). Cross and other scholars are critical that as harm reduction has been appropriated by mainstream healthcare that it has tended towards an overly

medicalized focus on controlling individual risk factors and has become depoliticized (Hyshka et al., 2017; Lightfoot et al., 2009; Roe, 2005; Smiles et al., 2023); although, I argue that a lack of political action is not apolitical or depoliticized. In the current political climate, harm reduction has become a highly political wedge issue among populous conservative politicians. Given this backlash, harm reduction nursing can hardly be considered apolitical.

Political Action Versus Risk Reduction. Since the early grassroots emergence of harm reduction until today, professionals working within public health frameworks have shifted the philosophy of harm reduction from collective care and political action towards individual risk reduction through behaviour modifications, which in itself is a normalized and dominant political ideology (i.e., neoliberalism) rooted in colonialism (Kusdemir & Oudshoorn, 2023). Harm reduction expanded from its grassroots activist history and is now a mainstream public health framework for approaching substance use in Canada. Harm reduction is one of four pillars in the government's strategy to address substance use, other pillars include prevention, treatment, and enforcement (Sue, 2021). Historically, substance use was treated as a criminal justice issue with enforcement and incarceration receiving most funding (Michaud et al., 2024). A biomedical model and trauma informed lens can be a less stigmatizing approach to care for people that are made vulnerable and marginalized by a society that often views illicit drug use and street involvement as morally wrong, socially deviant, and criminal (Pauly, 2008). Alcohol and tobacco also result in a substantial burden of disease and social harms (Hall et al., 2023); although their use is legalized and more socially acceptable than other substances (Shahid & Neufeld, 2024).

Undeniably, substance use is a medical and healthcare issue. However, an overly medicalized approach may imply that all illicit drug use (e.g., illegal street drugs or pharmaceutical-grade government controlled drugs obtained without a prescription) or illicit

drinking (consumption in prohibited areas) is problematic use (Cross, 2017). Medicalized approaches may suggest all illicit substance use is linked to trauma or is a biomedical disorder (i.e., addiction and/or mental illness) to be solved by HCP (St. Arnaud, 2023). Although, the illicit Canadian drug supply has become increasingly toxic, not all substance use is problematic. Similar to the use of legal substances (e.g., alcohol) people also use illicit substances for pleasure, and not solely to cope with trauma/pain. A biomedical model often ignores the role of pleasure in people's substance use behaviours (Cross, 2017; Hanoa et al., 2024; Smiles et al., 2023). As noted earlier, many of the harms of substance use relate to harmful drug policies.

Harm reduction interventions by HCPs have typically focused on minimizing the health-related harms of substance use through mitigating individual level risk factors (e.g., preventing and responding to overdoses and reducing transmission of HIV and other STBBIs). Within public health frameworks and government harm reduction policies, strategies of risk reduction through social control over behaviours among individuals is not unexpected (Cross, 2017; Hyshka et al., 2017; Kusdemir & Oudshoorn, 2023). Additionally, harm reduction services ran by HCPs are typically government sanctioned and funded. Political action may be a conflict of interest or risky endeavor among employees that depend on government funding and policy approvals to continue their work (Lightfoot et al., 2009).

Lack of Peer Involvement. Harm reduction is a philosophy of care and a sociopolitical grassroots movement led by, for and with people who use drugs (Goodyear, 2021; Kerber et al., 2020; Roe, 2005). The term *peer* in harm reduction work, refers to people with lived experience (Greer et al., 2016). People who use drugs and their respective peer-led organizations have also worked to mitigate individual-level risk factors in similar ways to HCPs (e.g., distributing naloxone); however, peer-led organizations are less restrained in their interventions compared to

HCPs, in part because they are less tied to government (Cross, 2017; Piatkowski et al., 2024). Peer-led organizations have engaged in collective political action, adapted more quickly to rapidly evolving situations, are often more responsive to the needs of substance users to develop unsanctioned grassroots programs that challenge systems-level harm (e.g., advocating for decriminalization, starting compassion clubs and other forms of unsanctioned safer drug supply and running peer-led overdose prevention sites; Cross, 2017; Piatkowski et al., 2024).

Ideally, harm reduction interventions should support the disability activists' mantra of 'nothing about us without us' that has since been adopted by many marginalized groups, in relation to programs and services that are intended to serve them. When it comes to developing programs and interventions power should be in the hands of people with lived experience (Greer et al., 2016). However, in practice these grassroots values are not always upheld by HCPs and policy makers. Programs and services are often developed by external stakeholders and people with academic, clinical, and/or bureaucratic expertise without any input from people with lived experience (Cross, 2017; Greer et al., 2016; Hyshka et al., 2017; Norman & Pauly, 2013).

Excluding People Who Use Alcohol. Harm reduction is also critiqued for excluding people who don't use illicit drugs and primarily experience alcohol related harms. For example, criminalization of "illicit drinkers" who consume alcohol in prohibited public spaces, people who drink alcohol not intended for human consumption such as hair spray or mouthwash because liquor stores/bars may be inaccessible to them for various reasons such as location, hours of operation, or racism/discrimination from employees (Bailey & Masuda, 2024; Campbell, 2008; Pauly et al., 2016). Bailey and Masuda (2024) described a cordon therapeutique that emerged in Vancouver's Downtown Eastside in the 1980's in the form of a liquor permit moratorium. The Downtown Eastside is notorious for visible drug use, homelessness and poverty

and it is also home to a large community of Indigenous Peoples (Benoit et al., 2003; Goodman et al., 2017; MacCandless, 2013). Bailey and Masuda (2024) found the moratorium resulted in virtually no liquor stores to purchase alcohol that was safe for human consumption, and few establishments where alcohol could be consumed in public. Single occupancy rooming houses and hotels were common in the area; therefore, even people who were not homeless were limited in where they could go to safely consume alcohol and socialize with others (Bailey & Masuda, 2024). Laws banning drinking in public are often rigorously enforced, which can result in unsafe drinking habits among people experiencing homelessness, including consuming large quantities of alcohol in short time frames to avoid it being confiscated by police or stolen by others (Pauly et al., 2016). During the pandemic, laws banning alcohol consumption in public were relaxed in certain Vancouver parks to allow for socializing with friends and family in safer outdoor spaces with social distancing measures. Yet, no parks within the Downtown Eastside were approved for public consumption, and instead approval was mostly limited to parks in places where White middle and upper class people would frequent (Bailey & Masuda, 2024).

Ignoring Intersection Oppressions. Harm reduction faces criticism that services are often approached in gender and race neutral ways that in reality cater to people that are White and/or male (Boyd et al., 2018; Cross, 2017; Daniels et al., 2021; Godkhindi et al., 2022; Rosales et al., 2022; Wardman & Quantz, 2006). Unfortunately, even seemingly benign policies in harm reduction can cause racial and gender-based harms. Based on findings from Boyd et al. (2018), I argue policies that ban assistance (provided by either nurses or peers) with injecting drugs at safe consumption sites (SCS) and overdose prevention sites (OPS) may exacerbate the problem of murdered and missing Indigenous women. Their study found that since women are more likely to rely on assisted injecting than men, these policies deterred access to care among women and

put them at risk. Participants (N=35 women, twenty of whom were Indigenous) described how the policies forced them into alleys and other unsafe places where they relied on informal injecting partnerships with male acquaintances and romantic partners, which increased their risk of various harms. SCS not only prevent overdose, but staff can also protect women from violence when they are intoxicated or passed out. Additionally, women were at greater risk of STBBI transmission from being "second on the needle" when using drugs with men, a practice that is based in patriarchal norms (Boyd et al., 2018). Informal injecting partnerships with untrained people are a risk factor in overdose and Indigenous women experience five times more fatal overdoses than non-Indigenous women (Boyd et al., 2018). Participants suggested that even when policies permitted assisted injecting, many peer workers at SCS were White men. Indigenous women reported that they would feel more comfortable receiving assistance from fellow Indigenous women hired as peer workers (Boyd et al., 2018). Clearly, there must be more harm reduction programs designed with, for, and by Indigenous women and training provided to meet the needs of people in the community.

Harm Reduction Backlash—Everything is Broken

In the previous sections, I discussed critiques from within the social world of harm reduction. I now move onto exploring the political backlash to harm reduction that is rooted in moral judgments related to colonialism. In 2022 Pierre Poilievre, the leader of the Conservative Party of Canada (Canada's official opposition party), stood in-front of a Vancouver encampment and proclaimed, "everything feels broken" (Poilievre, 2022). "Everything *Is* Broken" soon became his campaign slogan for the 2025 election and his problematic views on the concurrent homelessness and overdose crises gained public traction. Media influencers and conservative politicians, including Poilievre and Ontario's conservative Premier Doug Ford, have frequently

referred to SCS as “drug dens” and people experiencing homelessness and living in encampments as “street addicts,” othering them, while working to generate sympathy for so called “innocent victims” (Benzie, 2024b; Huston, 2024; Muschi, 2024; Sarkonak, 2024).

These social constructions of innocence versus immorality and vice are rooted in histories of colonialism, as described earlier. Researchers found that both race and class are implicit in judgmental and stigmatizing language in the media (Michaud et al., 2024; Moeke-Pickering et al., 2018; Nelson et al., 2016). Moreover, most news articles on substance use and homelessness do not mention Indigenous Peoples (or their rights) at all, despite the many Indigenous people affected by homelessness and lost to overdose deaths (Challand, 2023; Johnston, 2020). The situation is not hopeless, and news media also offered some positive counter-narratives, public support for harm reduction, and encouraged compassionate responses towards people living with homelessness. In this chapter, I solely focus on political backlash and racist/classist discourses, because these are the discourses CHNs must fight against in their work.

Public Outcry Versus Evidence Based Decisions. Poilievre put forth narratives that pitted public interests against the needs of people experiencing homelessness and substance use. He sought to villainize provincial and federal Liberal governments’ harm reduction policies and programs for harming innocent victims including children, youth, and middle-class families. Provincial conservative politicians followed suit and rolled back harm reduction policies and denigrated this evidence-based approach to substance use in the media (Culbert & Brender, 2024). In many jurisdictions globally, including North America, drug paraphernalia laws criminalize possession of supplies that prevent transmission of STBBIs (Hill et al., 2024). The UN (2015) argued that these laws violate human rights to health and healthcare. Human rights frameworks must inform ethical harm reduction and substance use policies.

Nurses and harm reduction workers across Canada (albeit in different ways across the provinces) are being constrained in their provision of needles, inhalation pipes for smoking crack cocaine and methamphetamine, and other supplies for safer drug use. In Ontario, most safer drug use supplies are currently publicly funded and free for users to access; however, it is important to highlight the rapidly evolving situation of harm reduction and homelessness. At the time of writing this chapter, Doug Ford and his conservative government had announced the closure of 10 of the province's 23 SCSs, and the remaining sites are under intense scrutiny. Some sites will be transitioned to Homelessness and Addiction Recovery Treatment (HART) hubs, which will not be permitted to provide needles and pipes or offer safer supply programs (Government of Ontario, 2024) Therefore, as these SCSs transition to HART hubs safer drug supplies will become less available in many urban areas in Ontario. Anti-harm reduction policies are being rolled out in other provinces. For example, Saskatchewan's conservative government under Premier Scott Moe, will no longer provide educational materials on how to use drugs more safely, and has also banned third party organizations (e.g., non-profit or peer-led organizations) from using government funds to provide these materials (Salloum, 2024). Politicians at various levels (federal, provincial and municipal) have argued handing out pipes sends the wrong message. This intervention is being defunded or banned outright in some provinces (e.g., Saskatchewan; Langager, 2024) and more regions could follow, despite that it is an important intervention to stop Hepatitis C virus (HCV) transmission (Stroffolini & Stroffolini, 2024).

HCV treatment is far more expensive than glass pipes, and thus providing supplies are both effective and cost containment strategies (Stroffolini & Stroffolini, 2024). Needle supply and exchange programs also prevent HIV transmission, which is well studied (van Santen et al., 2023), and politicians and the public generally acknowledge benefits. However, there is public

outcry over needle and other drug debris and needle exchange programs are being severely restricted (Government of Ontario, 2024). With this outcry, some harm reduction programs may be forced to return to outdated policies of strict one-to-one needle exchanges, which are not evidence based and could limit peoples' access to safer drug use in many parts of Canada (Salloum, 2024). Moral judgment has overtaken economic and evidence-based decision making in anti-harm reduction policies. Moreover, these policies are not race neutral, given STBBIs disproportionately impact Indigenous populations (Lee et al., 2023). Indigenous women (living in both rural and urban areas) have one of the fastest growing rates of new HCV and HIV infections in Canada, and in particular Saskatchewan (Boyd et al., 2018; Cheekireddy et al., 2022). Indigenous people have reduced access to treatment and advanced progression of these treatable diseases due to discrimination in healthcare (Jongbloed et al., 2017; Lee et al., 2023).

Capitalist Intersections Between Race and Class. People who are homeless, impoverished drug users, and people with mental illness are often seen as a drain on society by people in more privileged positions and they desire social and physical distance from them (Canham et al., 2024; Pescosolido et al., 2021). Visibility of homelessness and public drug use is deemed unacceptable among business owners and "tax payers" who feel their rights to access public spaces, that their taxes supposedly pay for, are violated by encampments (Rady & Sotomayor, 2024). While standing in front of a construction site in Cobourg, ON, Doug Ford controversially suggested that people living in encampments should "get off your A-S-S and start working" (CHCH News, 2024). Barrie city council proposed a bylaw in 2023 that would have made it illegal for charitable organizations to distribute food and other essential items to people sheltering on public property and backed off only when groups agreed to end outreach along the desirable waterfront areas (Draaisma, 2023). Riley Brockington, an Ottawa city councillor,

questioned the metrics of success used by a harm reduction focused supportive housing program and suggested healthcare was not being provided in the program, despite a partnership with a community health organization, the daily presence of multiple nurses on site, and personal support workers around the clock (Lee, 2024). Brockington and other community members argued that a true measure of program success would be whether or not residents living in supportive housing got jobs (Lee, 2024). Classism is at work in these discourses, but racism also cannot be ignored when many of the people affected are Indigenous. Moreover, these classist discourses align with overtly anti-Indigenous stereotypes such as the "drunken lazy Indian" and other overt stereotypes about substance use, being a welfare burden, not paying taxes, and taking advantage of settler Canadian tax payers (Brockman, 2016).

Doug Ford offered to use the *Charter's "*Notwithstanding clause" on behalf of Ontario municipalities who want to clear encampments, in spite of courts' injunctions that block removal of the people living in them (Benzie, 2024a). Ford insisted that it is time to "move them along" despite that people have nowhere to go and he proposed up to $10,000 fines and 6 months in jail for drug use in encampments (Benzie & Ferguson, 2024). Courts have sided with people experiencing homelessness and reasoned that if there are no shelter spaces available, then forcing people to leave encampments and destroying their tents and makeshift shelters are against basic human and Charter rights. Thus, Ford's proposed use of the "Notwithstanding clause" to overrule the courts, arguably fails the legal test of what is ethical and just. His proposed actions unethically threaten one's human right to simply exist in public spaces, forces vulnerable people to hide in unsafe places around the city, and leaves people without the basic human right to shelter in the midst of the harshest winter months in Ontario. Encampment clearing causes immense harm and even death (Chang et al., 2022; Hall, 2022). Again, I underscore the

disproportionate impacts of encampment clearings among Indigenous people because they are more likely to be homeless, to not be in shelters, and to be sleeping rough on the street. In relation to homeless encampments, some scholars emphasized Indigenous Peoples legal rights to the lands they occupy in encampments (Braimoh et al., 2023; Lund, 2024). Land claim battles pit capitalist/state/taxpayer interests against Indigenous rights.

Nursing Implications of Current Political Backlashes

Harm reduction philosophies are a major paradigm shift away from abstinence and prohibitionist approaches to substance use, towards a more ethical approach with people experiencing homelessness who use substances. Despite this paradigm shift, nurses have not eliminated their continuities with histories of colonial oppression. Many nurses may not be aware of the ways in which racism and colonialism are bound up with Indigenous homelessness and prohibitionist substance use policies. Nurses and other HCPs have largely embraced neoliberal approaches of harm reduction rooted in individualized risk reduction to address public health and population level inequities. Nurses have, at times, stood with activists and engaged in unlawful actions towards decriminalization of drugs, but overall their approaches are more medicalized (Foreman-Mackey et al., 2019; Lightfoot et al., 2009; Longhurst & McCann, 2017). Medicalized routes that focused on risk reduction may have been strategically essential to gain legitimacy and government funding for harm reduction programs. However, given current backlashes against harm reduction in Canada, nurses must turn back towards grassroots histories of harm reduction as a social movement and engage in political action.

Multiple Truths, Silencing Others, and Racist Power

As nurses embark on political action against suffering and harm, it may be helpful to consider how multiple truths are silenced in the political realm. Conservative politicians in

Canada (e.g., Alberta's Premier Daniel Smith, former Prime Minister Stephen Harper) have histories of silencing others, including Indigenous Peoples, scientists, nurses, HCPs, and denying people's professional and lived expertise (Roberston, 2023). For example, Dr. Doris Grinspun CEO of the Registered Nurses' Association of Ontario argued that harm reduction policies be upheld and funding restored. In response, to Grinspun's political advocacy, Poilievre's media relations posted on X that she was a "wacko" and "so called expert" with "23 letters behind her name" (Skamski, 2024). Globally, populist conservative politicians have demonized and fired chief medical officers, physicians, and public health experts in the wake of COVID 19, and replaced them with people who perpetuate medical misinformation (Kweon & Choi, 2024).

In the previous sections, I described policies, statements, and actions among conservative politicians that cause immense harm to Indigenous people experiencing homelessness. Moreover, all of these harmful policies and discriminatory practices are rooted in unethical moral judgments about people living on the margins of society. Vulnerable people are being denied their basic human rights to healthcare and shelter (Olson & Pauly, 2021). Butler (2016) argued that death is an inevitable reality for everyone, and thus all lives are precarious; however, precarity is a politically induced condition whereby some lives are made more vulnerable to suffering and harm than others. Anti-harm reduction policies and encampment clearings will inevitably lead to human suffering and avoidable deaths and illustrate politically induced precarity. This leads us to question: Who is deemed worthy of compassion and care? Whose lives matter and why?

Butler has argued that "without grievability, there is no life, or, rather, there is something living that is other than life. Instead, 'there is a life that will never have been lived', sustained by no regard, no testimony, and ungrieved when lost" (2016, p. 15). This leads to the next logical question: Whose lives do we grieve? Fraser et al. (2018) described the public backlash to a

proposed overdose monument in Australia with public comments questioning why commemorate criminals “who died from their own stupidity” and media headlines such as “Monumentally Stupid” (p. 28). It is important to publicly grieve deaths of people experiencing homelessness, and to share testimonials to their lives and humanity, but these testimonials will not be enough to generate compassion, nor ensure ethical policy changes. Dertadian and Rance (2023) found in their study of Australian media that, “the more aligned those who die by overdose are with mainstream, White, and middle-class culture, the more media coverage frames their lives as worthy of grieving” (p. 376). In Canada, media also tended to portray some overdose victims as more sympathetic (e.g., young, White, suburban, middle class) and rarely represented the humanity of Indigenous people who have been lost to overdose and homelessness (Johnston, 2020). Studies have clearly shown that it may be a challenge to simply (re)produce a sympathetic victim in testimonial networks if the victim is anything but white and male, which is particularly apparent in coverage of murdered Indigenous women and girls (Gilmore, 2017; Moeke-Pickering et al., 2018; Shah, 2021; Singh, 2015). Butler argued that racism “at the level of perception tend to produce iconic versions of populations who are eminently grievable, and others whose loss is no loss” (p. 24). Racism normalizes violence against Indigenous Peoples, while racist policies increase their political precarity to harm.

Nurses must bring the concerns of the individuals they serve into the political realm. Testimonial knowledge travels through networks across time and space in search of adequate witnesses and redress (Gilmore, 2017). Nurses must consider how the concerns of marginalized people will be received by others in society including mainstream media, policy makers, and the general public. Messages must be carefully crafted in order to avoid causing further harm to marginalized individuals and communities. However, the message is not the only component that

will be judged by others, the messenger will be judged as well. Stories, and the people that share them, encounter judgments. In thinking through testimonial networks and tainted witnesses, I make the connection to nurses' responsibilities to uncover difficult truths about racism and settler colonialism. I argue that nurses' responsibilities at the point of care are not to evaluate historical truth claims of Indigenous Peoples, but rather to bear witness to the multiple phenomenological truths of others and to respond with unconditional compassion. It is unethical to withhold compassion based on a lack of understanding of someone or something.

Phenomenological truth is another form of truth, where lived experiences, and multiple realities and meanings reside (Oliver, 2001). The truth of colonialism, racism, heteronormativity, and sexism bound up with trauma and suffering cannot be reduced to bare historical facts. Even nurse historians and researchers who arguably play a role in evaluating historical truth claims must use extreme caution when attempting to unearth, interpret, and represent historical facts. History is never objective. Historical inaccuracies are often used to discount the stories of people experiencing race and/or gender based violence (Felman & Laub, 1992; Gilmore, 2017). Testimonials related to violence and oppression may contain inconsistences and inaccuracies because of the impact of trauma on memory (Felman & Laub, 1992; Gilmore, 2017; Herman & van der Kolk, 2020). For example, Gilmore (2017) described how gender and race intersected in discounting Rigoberta Menchu and her testimonial of genocide committed against her own Indigenous community in Guatemala. Her testimony was also discounted on inconsistencies related to trauma. Oliver (2001) described how White male historians were ready to dismiss testimony of a Jewish woman that had witnessed a prisoner uprising at Auschwitz because she incorrectly testified that she had seen four chimneys blown up when in actuality there was only one. Phenomenological meaning underlying survivors' testimonies make profound contributions

to research and generate important new insights, despite historical inaccuracies (Oliver, 2001). Nurses have an important ethical responsibility to bear witness to violence, oppression, and suffering and advocate for compassionate responses from policy makers in positions of power. Testimonial knowledge also has important implications for exposing historical truths about colonial practices in nursing.

Psychoanalytic truths relate to our unconscious which underlies conscious thoughts and the meaning we ascribe to things (e.g., events, other people, objects). Oliver (2001, 2004) discussed psychoanalytic truths versus historical truths in detail. She described how the uncritical acceptance or rejection of truth based on historical facts is problematic, for example, when stories are discounted based on inconsistencies that occur in testimonies related to trauma. Critically analyzing our own unconscious is requisite to ethical subjectivities. Racism and oppression in nursing often manifest as a lack of compassion and denial of experiences that others are living or have lived through. Therefore, compassion and an openness to suspend moral judgment and instead bear witness to truths of others are requisite for ethical relational nursing practices. Oliver argued that without accounting for the unconscious

> we risk self-righteously adhering to deadly principles in the name of freedom and justice. We risk taking the defensive posture of isolationism and individualism that protects itself by attacking others, becoming absolutely unforgiving in its attempts to silence others and cut off their ability to respond. (Oliver, 2004, p. 87)

Oliver wrote about these risks 18 years ago; however, her words are particularly relevant in the current sociopolitical climate in the wake of the COVID 19 pandemic. Populist right-wing politicians continue to embolden each other globally and mobilize people on the far right with their more and more overtly racist rhetoric and success in pushing forward repressive policies

and denying human rights. In our current Canadian situation, nurses are on the receiving end of hostility related to vaccine mandates, public health measures, and a healthcare system that had essentially collapsed in the wake of the pandemic with ED closures and staffing crises. CHNs are witness to the suffering of COVID 19, the overdose crisis, and the homelessness crisis, while populist politicians continue to perpetuate hostility and deny nurses a political voice. Arguably, we can't educate racist power away—action is required.

Mitigating Racist Power Through Ethical Actions

The desire for racist power cannot be educated away and both Kendi (2016, 2019) and Bonilla-Silva (1994, 2021, 2023) have argued that education is ineffective in eliminating racism. In 1994, Bonilla-Silva stated that he disagreed with the consensus of most social scientists at the time who believed education would cure illogical and racist beliefs. This cure suggests that through education people would realize their beliefs or behaviours were false and/or morally wrong; therefore, racism would disappear (Bonilla-Silva, 1994, 2021, 2023; Kendi, 2016, 2019). The TRC (2015) also made a number of calls for education including among nurses. I agree that education is critical, but it is not the only intervention that is needed to eliminate systemic racism and racist policies. Kendi (2019) argued "moral and educational suasion breaths the assumption that racist minds must be changed before racist policy, ignoring history that says otherwise" (p. 208). Cohort replacement and increasing education levels have failed to eliminate racial inequities and racism has simply become more covert (Bonilla-Silva, 2023; Kendi, 2016). Educational cures are rooted in false ideas that racism is about ignorance, and not power. Canada's histories of colonial oppression and violence against Indigenous Peoples underscores that racism has always been, and still is, about power over territories and resources (Daschuk, 2013; Teillet, 2019). Racist policies are created out of self-interest and have historically only

been changed when self-interest aligns with doing the right thing (Kendi, 2019, 2016). Political protest is vital but gaining control over policy making is more sustainable. Kendi (2016) argued for change to be sustained that anti-racist people must be supported and put into positions of leadership and political power.

Throughout my thesis, I develop an important point—policies that disproportionately impact Indigenous people experiencing homelessness are not race neutral policies. These policies are racist. Similarly, policies in the realm of community/public health, harm reduction, and homelessness that disproportionately impact women and 2SLGBT+ people are not gender-neutral policies and many policies simultaneously oppress people based on their multiple identities and intersecting social positions. These oppressive policies are rooted in settler colonial worldviews and White supremacist social processes and must be analyzed through an anti-colonial lens. Nurses need to explore how they can contribute to dismantling racist policies. An intersectional analysis of government harm reduction and homelessness policies is urgently needed to identify the differential impacts these policies have among Indigenous people experiencing homelessness, and in particular with Indigenous women and gender diverse people that use substances. I argue that anti-harm reduction policies being pushed forward by politicians are actually racist policies rooted in colonialism. I began to explore the problem here and acknowledge that a more fulsome analysis is beyond the scope of my study, but nonetheless must be undertaken in future studies.

On the journey towards anti-racism, it is critically important to identify the White racial behaviours among nurses that uphold settler colonial systems and thus perpetuate racial inequities. Additionally, for nurses to engage in this deep and critical reflexivity requires strong theoretical understandings of systemic racism, social processes, social structures. Systems may

be described as broken when they cause harm and disparities in health and wealth among groups of people. Unfortunately, these systems are not broken and unfair advantages were built into colonial systems from the start. Inequitable systems are functioning precisely how they were designed to function. The notion of a broken system suggests that racial harms are accidental and cracks in systems simply need to be fixed. However, racist systems must be exposed so that they can be dismantled and redesigned. When a few bad apples are highlighted by researchers or the media this may, unintentionally or strategically, detract from the problem of racist systems.

Moreover, it may be difficult to tease out the racism in harmful, but seemingly race neutral policies. Settler colonialism represents multiple intersecting oppressions (e.g., White supremacy, patriarchy, class). Assumptions that power between nurses and Indigenous people experiencing homelessness are based solely on one system of oppression (i.e., race) is an oversimplification. Poverty, mental illness, substance-use, and gender-based violence add layers of oppression, regardless of race in the context of all my previous nursing roles (rural and remote northern hospitals, acute care, harm reduction) where I encountered persons experiencing homelessness. Intersectionality emphasizes that all forms of privilege and oppression are fluid, relational, and situation specific (Crenshaw, 1991). An anti-colonial lens may reduce the importance of separating various forms of oppression, prejudice, and discrimination into discrete categories (e.g., race versus culture, religion or ethnicity), because it is underpinned by the assumption that colonial systems of oppression are entwined. However, intersectionality must not minimize the central role of racism as an organizing and central feature of Canadian settler colonial social systems and structures.

In this chapter, I analyzed media articles and political statements. I intertwined this analysis together with a discussion of academic literature and my theoretical framework of

Oliver's witnessing ethics. I introduced important situational elements including stereotypes about Indigenous Peoples in healthcare and discourses about harm reduction, substance use, and homelessness circulating within media and political arenas. I began by drawing attention to historical elements including the racist history of drug and alcohol policies in Canada that contribute to the harms experienced by Indigenous people experiencing homelessness including racism in healthcare and access to SDH. I explored nurses' roles in colonialism. CHNs had and still do have access to intimate spaces and private homes, which allowed for CHNs to directly interfere in Indigenous family life and disrupt their cultures. Discursive constructions of nurses as angels were used as a tool to control so-called vices and serve dominant settler interests. Next, I explored systemic racism and White racial behaviours that uphold settler colonial systems. Finally, I returned to the social world of harm reduction nursing and exposed some of the current political backlash in Ontario and Canada that influences CHNs work. In the next chapter, I offer a relational ecological overview of CHNs' social worlds and arenas, which marks the start of my analysis of interview data and sets the stage for subsequent chapters.

Chapter Four: A Relational Ecological Overview of the Situation

"It should perhaps be emphasized, though, that what is being judged here is not the speaker, but the speech—not the individual, but the tools at her disposal for thinking through race."

Ruth Frankenberg – White Critical race scholar and feminist (1988, p. 5)

This chapter marks the start of my situational analysis where I present findings from my qualitative interviews with CHNs. As I move into statements made by CHNs, the direction of judgment that Frankenberg highlighted above is critically important to consider. I do not judge the participants for any potential blind spots or misperceptions. They genuinely cared about the problem and deeply are committed to anti-oppression work. I am grateful for the valuable insights they shared with me. Blind spots about racism are not a reflection of one's moral character but rather reflect poorly on the tools that have been offered to nurses to think through racism. Cultural competency and cultural safety are frameworks commonly extended to nurses to think through cultural diversity, but they are ineffective tools to think through racism and oppression, especially at the systems level. As the previous chapter argued, CRT and anti-colonialism are more effective theoretical tools to explore systemic racism and the many intersecting oppressions that cause Indigenous homelessness and health inequities.

Additionally, cultural beliefs and circulating discourses about Indigenous Peoples rooted in colonialism and White supremacy are the often-invisible waters in which we all swim. In the previous chapter, I discussed some problematic discourses circulating in the media, which reflect public perceptions and re-present various political points of view. I also explored some of the many intersections between harm reduction nursing, Indigenous homelessness, and histories of colonialism. I further focused on how systemic racism functions and is upheld by White racial behaviours rooted in White supremacy. Unfortunately, actions are also constrained by the

situation in which one finds themselves in. Many situational elements are beyond individual control. In the following sections, I provide a relational ecological overview of the site of CHNs anti-colonial struggles and nursing actions. This chapter also illustrates the use of mapping in situational analysis, and I present three kinds of maps, a social worlds and arenas map, an ordered map of situational elements, and a positional map of discursive positions and silences found in the situation. This chapter provides a broad overview of the situation.

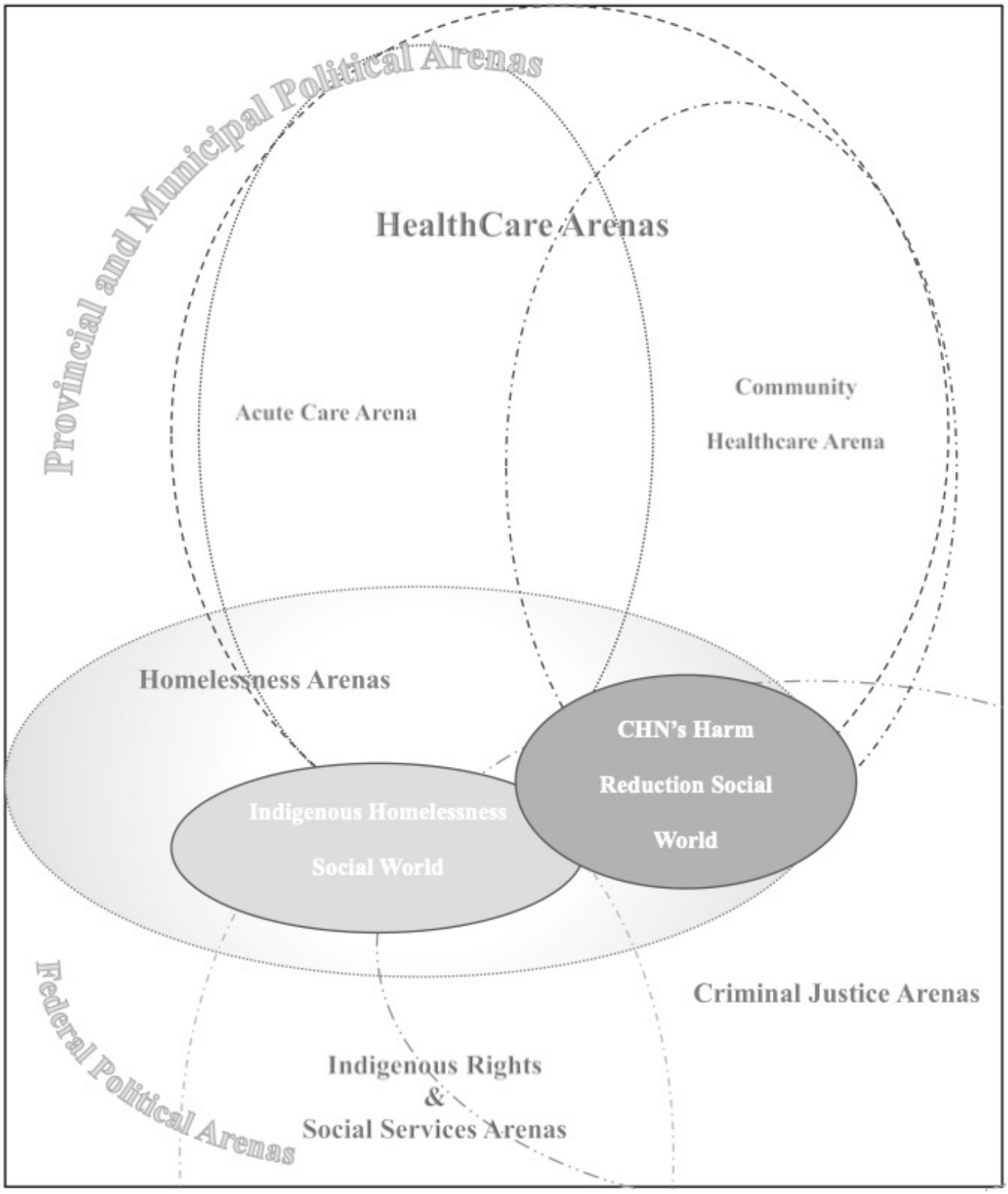
To begin, I situate CHNs social world of harm reduction within broader arenas and points of contact with other social worlds. Next, I describe my sample demographics of CHNs that participated in interviews. Other data sources included news media articles, academic literature, websites, publicly available documents, and informal observations and reflections on my work as a harm reduction nurse and the world around me. Using all of the various sources of data, I offer a relational ecological overview of situational elements. Circulating discourses are an important aspect of situational analysis, and I focus on two types. The first is circulating discourses in the media, which were discussed in the previous chapter. The second type of discourses are the CHNs' discursive constructions of the situation, which will be discussed in this chapter.

Locating CHNs Social Worlds and Anti-Colonial Struggles

Figure 4.1 presents my social worlds and arenas map, which situates CHNs social worlds and anti-colonial struggles within the broader arenas and intersections with other social worlds. CHNs' social world is at the intersections between broader healthcare and homelessness arenas, Indigenous rights and health arenas, and criminal justice arenas. Provincial and federal politics surround the situation from multiple overlapping directions. For example, healthcare and housing are primarily provincial responsibilities; however, Health Canada, which is a federal government institution and municipal public health agencies also exert influence in the situation.

Figure 4.1

Social Worlds and Arenas Map



Harm reduction and homelessness are drawn into multiple political arenas because they are highly politicized at all levels of government. Healthcare is provincial, but harm reduction involves policies at the federal level (e.g., controlled substance acts and legal exemptions to criminal codes to operate SCS), and may also require support from law enforcement, and receive funding from municipalities and provinces. Criminal justice arenas cross through federal, provincial, and municipal political arenas in a multitude of ways; for example, through federal criminal codes, federal and provincial laws, prisons, and court systems, and multiple levels of funding and policing jurisdictions at municipal, provincial and federal levels. Indigenous health arenas are primarily within federal jurisdictions, at least among status First Nations and Inuit (e.g., Indigenous Services Canada funds some Indigenous specific health services in urban areas, operates the non-insured health benefits (NIHB) program, and is responsible to provide on-reserve housing and healthcare). Indigenous rights (e.g., land claims, housing, access to SDH and rights to access healthcare free from discrimination) cut across multiple jurisdictions.

The social world of harm reduction nursing, as illustrated by my social worlds and arenas map, is located within the broader arenas of community health and healthcare more generally, and it intersects with multiple arenas and social worlds, as described above. Acute care is separate from community health, but CHNs often continued to follow people as they moved in and out of acute care. They shared information by sending letters with clients and/or paramedics, made numerous phone calls to acute care nurses, attending physicians and other allied healthcare providers (e.g., social work, occupational therapy), and sometimes attended hospitals in person to advocate at case conferences, plan discharges, or simply be present and support clients with no family. CHNs were able to view hospital EMRs and often coordinated care with outpatient specialists in the hospital setting (e.g., infectious diseases, orthopedics).

Some CHNs in the study provided care within the walls of a CHC, but many also provided outreach. They went directly onto the street to reach clients, and worked within shelters, supportive housing, and rooming houses. Therefore, CHNs that worked in harm reduction also worked extensively within the homelessness arena. They worked to find housing for clients, ensured clients had all the necessary documents, and ability to pay rent through filling out Ontario Disability Support Program (ODSP) and Ontario Works (OW) applications. CHNs in harm reduction typically worked with some of the most marginalized people in society, and they focused their efforts on reducing the harms of substance use and other related street involved behaviours. Therefore, many, but not all, of their clients had lived experiences of homelessness and/or were at risk of homelessness and/or were living in inadequate/unsafe housing that did not meet their needs. Within their outreach roles, CHNs also served people experiencing or at risk of homelessness that had poor mental and/or physical health, but that did not use substances.

High rates of homelessness among Indigenous people also connects to Indigenous rights and services arenas; and yet, CHNs interviewed in the study seemed to have only peripheral contact and knowledge of these arenas. Their contact was mostly limited to a few connections with Indigenous healthcare organizations, filling out NIHB forms, and/or connecting clients with cultural supports, either external to their own healthcare organizations or provided internally. Internal supports were typically contracted to external providers, and with a few exceptions (e.g., peer workers) were not provided by employees of CHNs' organizations. CHNs had no significant contact with Indigenous rights arenas, despite clear violations of Indigenous and human rights that are exemplified by high rates of Indigenous homelessness and health inequities. Nurses must be aware of their ethical and legal obligations to Indigenous rights (e.g., UNDRIP and TRC) and these obligations should guide nursing actions.

Compared to other areas of community health, harm reduction overlaps more extensively with the criminal justice arena. The growing problem of encampments within the homelessness arena means people living in them (and the service providers attempting to serve them) often come into frequent contact with law enforcement and may also have involvement in court systems as human rights to access shelter in encampments and use substances in public places are deliberated. Harm reduction involves work with people whose behaviours are often criminalized (e.g., buying, selling and using illicit substances, sex work, panning, and public consumption of alcohol). Some CHNs also worked within government sanctioned SCS that require criminal code exemptions to operate. Working with people experiencing severe mental illness and homelessness may require involuntary treatment, which also brings both the nurse and client into contact with law enforcement and court systems. The criminal justice arena was not the focus of my study, but it is important to note that police officers and other first responders were discursively constructed by CHNs in the interviews as a source of discrimination and harm. Policies that intersect with homelessness and result in over criminalization and incarceration of Indigenous Peoples are examples of systemic racism and the ways in which race neutral policies can be racist were explored in chapter three.

Participant Demographics and Sample Description

Participant demographics are summarized in Table 4.1 below. CHNs were asked to describe their cultural, ethnic/racial, and gender identity to allow for people to self-identify in this regard. To protect participant anonymity, I do not include some of the specific countries of origin, nor do I connect gender together with cultural/racial descriptors, and I use gender neutral pronouns of they/them throughout the findings. One participant identified as male and the rest female. No participants self-identified as non-binary or transgender.

Table 4.1

Participant Demographics

Participant Demographics (self-identified)	CHNs (N=10)
Race/Cultural Identities	White (settler) n = 8
	Black n = 1
	Métis n = 1
Gender Identities	Male n = 1
	Female n = 9
Nursing Education	Diploma n = 1
	Bachelors n = 6
	Masters (completed or in progress) n = 3
Years in Nursing	3 - 24 years (mean = 10, median = 6)
Years in Harm Reduction Role	1 - 16 years (mean = 5.4, median = 5)
Acute Care Experience	Yes n = 8
	No n = 2

Eight out of 10 participants self-identified as White, Canadian, and/or settler before identifying their family heritage more specifically such as Irish, French Canadian, Franco-Ontarian, middle eastern country etc. One participant self-identified as Black and reported that they had immigrated from an African country as an adult, and one participant identified as Métis, but acknowledged that they 'passed' as White and were still learning about their family heritage. Although, there are times that I think it is important to make linkages between participant's responses and their racial identity, I do not link responses to markers of identity throughout the majority of the findings given the small sample size and risk of identifying participants.

Years of nursing experience ranged from 3-24 years (mean = 10 years, median = 6 years). Most participants had spent the majority of their nursing career working in harm reduction roles

in the community, and years in harm reduction ranged from 1-16 years (mean = 5.4 years, median =5 years). Eight CHNs also had acute care work experience and one participant had worked in rural/remote Indigenous communities. Education background varied from a college diploma (n = 1), bachelor's degree (n = 9), and/or master's degree completed or in progress (n = 3). A few nurses (n = 3) reported that nursing was a second career and that they held bachelor's degrees/diplomas in other disciplines (e.g., psychology, accounting, social studies). All of the participants had provided front-line nursing care in harm reduction, although one participant had recently left harm reduction within one week prior to the interview. One participant was in a leadership position, but still provided front-line care to people within their organization and the remainder of CHNs were staff nurses.

CHNs were busy providing front-line care; therefore, it was sometimes difficult to engage participants and for them to find time to participate during their work hours. Some participants agreed to be interviewed outside work hours, which suggested that they cared about the research topic enough to volunteer their time (i.e., outside paid working hours). A $20 coffee gift card was offered as a token of appreciation for participating, which was not a significant motivator to participate, and many CHNs were unaware of the incentive until after they agreed to participate. A few participants also felt that the card was unnecessary for themselves and intended to use their cards to support engagement with clients. CHN's that did not contact the researcher for an interview may have had different perspectives and experiences to share (e.g., they may have been anxious about their knowledge of the topic, fearful about speaking out against their healthcare organizations, may not perceive research on racism/cultural safety to be important, and/or may hold negative beliefs about Indigenous Peoples).

Despite attempts to obtain a diverse sample, I faced some challenges in this regard, and

the risk of selection bias must be acknowledged. First of all, only three organizations agreed to send out my recruitment email and to permit their staff to participate during their work hours. I had not intended to solely focus on CHCs and harm reduction nurses. Unfortunately, homecare agencies did not respond to my requests at all or directed me to head offices, which ultimately did not respond despite multiple attempts. One CHC declined to participate because they claimed that they did not serve many Indigenous clients, despite their staff doing outreach work into homeless shelters. The organizations that agreed to participate may place greater emphasis on cultural safety and supporting their Indigenous clients than organizations that declined to participate. Although only three organizations agreed to participate, other organizations are reflected in the sample, in the sense that participants had often worked for multiple different community health organizations in the past, and/or had heard about the study through word of mouth and agreed to participate on their own time unaffiliated with their respective organization.

All of the participants reported that they had taken additional training in Indigenous cultural safety, truth and reconciliation, or anti-racism. One of the organizations had mandatory Indigenous-led truth and reconciliation training, but the majority of participants had taken additional training (e.g., San'yas, the Path, or training offered by a local Indigenous health organization) of their own accord using their limited educational allowances. I suggest that the proportion of CHNs in my study that have additional cultural safety training is not typical of Ontario nurses or even CHNs in urban Ontario. Although there is a lack of data to support/refute this assumption, because the CNO does not track this data as part of their registration process. My sample may be different from the overall group of CHNs working in harm reduction in urban Ontario, based on their inclination to use their limited educational allowances on cultural safety training, and their desire to participate in my study. Importantly, as with any qualitative study, but

particularly so in this study, my findings are not transferable to all nurses or even all CHNs working in community-based harm reduction in urban Ontario.

A Relational Ecological Overview of the Situation

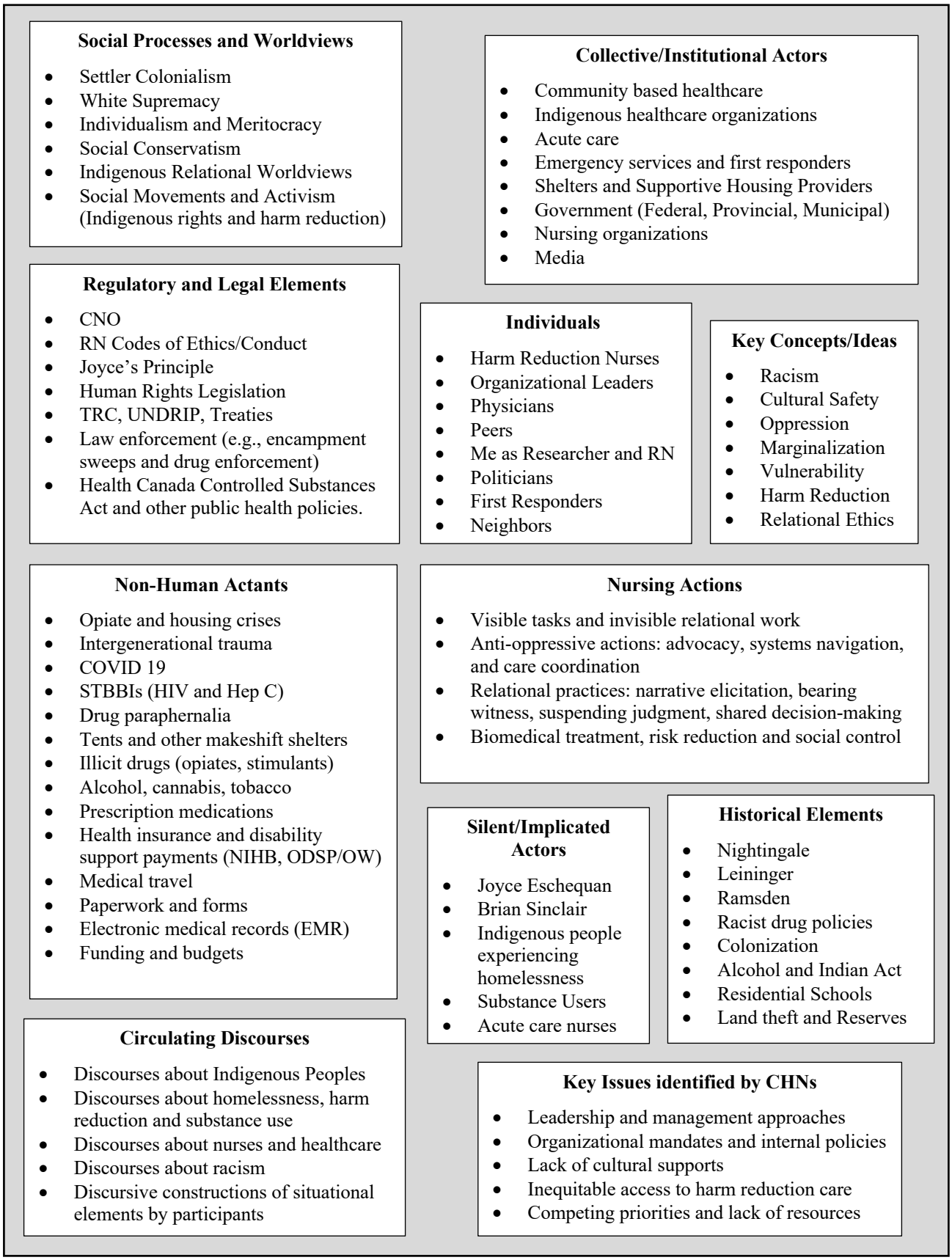
To begin this section, I return to my research question—How do situational elements influence CHN's engagement with anti-colonial struggles within themselves, within their harm reduction social worlds, and more broadly within the socio-political arenas of healthcare and urban homelessness in Ontario? I provide a relational ecological overview of situational elements that either emerged from interviews or that I identified as potentially salient based on my nursing experiences, literature review, and media watches. Some elements wield significant influence in the situation, but were not raised by participants, in part, because they are normalized social processes, invisible cultural aspects of settler colonialism, and/or histories that are not typically discussed in mainstream media or as part of nursing school (e.g., racist substance use policies, nurses' role in settler colonialism). Elements that did not emerge in interviews were pursued in my analysis of media and extant literature in the previous chapter.

Overview of Situational Elements

Figure 4.2 presents this relational ecological overview in the form of an ordered situational map. I grouped my elements according to the following categories: social processes and worldviews, key concepts/ideas, collective/institutional actors, individual actors, silent/implicated actors, non-human actants, historical elements, regulatory/legal elements, circulating discourses (including media and discursive constructions by CHNs). I included key-issues that CHNs highlighted in the interviews as being notable within in the situation. Finally, looking towards the center of the situational matrix (i.e. actions), I included nursing actions on my final situational map.

Figure 4.2

Relational Ecological Map of Situational Elements



I begin with a summary of each of the groups of elements on the map. Some elements I have already introduced in the previous chapters, which I summarize and expand on them in relation to other elements, but do not address them in detail. For example, non-human actants, social processes, and historical elements are woven through the circulating media discourses and CHNs discursive constructions of the situation. Following my overview of situational elements, I describe CHNs discursive constructions of Indigenous homelessness, and key issues.

Social Processes and Worldviews. Settler colonialism and White supremacy are world views and social processes that resulted in enduring political structures and remain deeply engrained in moral values and beliefs among settler Canadians (Bonilla-Silva, 2021; Coulthard, 2007; Dua et al., 2005; Gebhard et al., 2022; Russell, 2020; Wolfe, 2006). Individualism and meritocracy are colonial values that may be problematic in healthcare. Horrill (2021) noted that among oncology nurses, neoliberal discourses of individualism and egalitarianism combined with a lack of awareness of structural violence resulted in victim blaming and judgmental attitudes toward Indigenous Peoples. To my mind, many nurses that I worked alongside, who do outreach work, demonstrated greater understanding and compassion for individuals suffering from the ill effects of homelessness, substance use, and mental illness compared to some of my colleagues in acute care. Many CHNs, and outreach nurses in particular, witness first-hand the lived realties of homelessness (Paradis-Gagné et al., 2020; Pauly, 2005, 2014; Weber, 2019), which suggested that overall nurses in the community may have greater awareness of the impact of structural violence on health related choices and behaviours than their acute care counterparts. Systemic racism is also a social process and structural problem that emerges in the form of racist policies, which are perpetuated by White racial behaviours (Bonilla-Silva, 1994, 2021, 2023;

Kendi, 2016, 2019). These social processes were discussed at length in the previous chapter in relation to nursing histories, substance use policies, and harm reduction approaches to care.

Indigenous relational worldviews, which were introduced in the first chapter, are more community centric and directly oppose many of the individualistic values and beliefs rooted in colonialism (Ermine, 2007; Hart, 2010; Healey & Tagak, 2014; McCubbin et al., 2013; Wilson, 2008). Therefore, Indigenous rights movements and relational worldviews are counter narratives and counter movements to the problem of colonialism and racial inequities in health. Indigenous rights legislation and human rights frameworks ideally should inform CHNs' work (Olson & Pauly, 2021; Pauly, 2005; Pauly et al., 2021; Tisdale & Symenuk, 2020). I return to the issue of Indigenous rights and relational ethics in my discussions of UNDRIP and the TRC in chapter 6.

Indigenous rights movements (e.g., Idle No More), while pushing for Indigenous sovereignty and legal rights, have also targeted widening wealth inequalities that are rooted in capitalism (Barker, 2015; Simpson et al., 2018). Growing income disparities and a massive gap between rich and poor, contributes to homelessness among all peoples, settlers included (Byrne et al., 2021; Fowle, 2022). Capitalism also contributes to the climatic crisis that fuels further displacement among Indigenous Peoples globally, and may contribute to greater numbers of refugees who come to Canada and find themselves homeless (Adlam, 2020; Bezgrebelna et al., 2024; Bezgrebelna et al., 2021). Refugees, whom may not be given requisite supports to rebuild and recover from trauma, may further strain systems (Kaur et al., 2021) that CHNs were working within (e.g., shelters and healthcare), although this was not a focus of this study. Harm reduction, discussed in the previous chapter, is an important grassroots social movement and CHNs' area of practice. With the work of peer activists, this social movement may counter settler colonial

worldviews, and target harmful colonial policies in the interconnected realms of substance use and homelessness (Cross, 2017; Daniels et al., 2021; Hyshka et al., 2017; Marsh et al., 2015).

Historical Elements. Historical elements were discussed at length in the previous chapter. To summarize, these elements included histories of settler colonialism and racism in Canada. Nurses were called upon as a colonial tool of assimilation and social control over Indigenous Peoples (Krik, 2022a; McGibbon et al., 2014; Nestel, 1998; Waite & Nardi, 2019). Additionally, colonial violence continues to be perpetuated by nurses into the present day (Al‐Chami et al., 2024; Bell, 2023, 2024). Racist notions about drugs and alcohol are bound up with this nursing history. For example, Nightingale made inaccurate statements in her report on colonial schools and hospitals that connected high morbidity and mortality among Indigenous Peoples to alcohol and other so-called vices. Anti-Indigenous racism and stereotypes about alcohol are highly relevant within the social world of harm reduction.

Drug policies are also an important historical element. Harmful drug policies may be perceived as race neutral, and this is problematic in harm reduction work. In the past, drug and alcohol policies were often overtly racist (Campbell, 2008; Godkhindi et al., 2022). The overt racism of these policies evolved into more insidious forms of discrimination that at first blush may appear more classist than racist (Bailey & Masuda, 2024; Neufeld, 2023). It may be particularly difficult to tease out racism, as racially coded language has emerged into substance use discourses and media representations of the overdose crisis (Johnston, 2020). Discriminatory substance use policies violate people's basic human rights and have disproportionate impacts on Indigenous Peoples, and are therefore evidence of systemic racism (Marshall, 2015).

Individual and Collective Actors. As described earlier, the social world of CHNs were situated primarily within broader arenas of healthcare and homelessness. Other collective and

institutional actors included organizations that offer supportive housing, city council, federal and provincial governments, and Indigenous health organizations. Aside from CHNs, who were the focus of the study, other individual actors in the situation included organizational leaders, peer harm reduction workers, politicians, physicians, first responders, neighbors or other concerned community members. Politicians and their perspectives on substance use and homelessness were noted in media discourses discussed in the previous chapter. Some of these individuals (e.g., organizational leaders, concerned community members, politicians, first responders), were discursively constructed by CHN participants and/or their perspectives were represented by media, but they were not interviewed during this study. For example, police were discursively constructed as both causing harm and necessary, at times, to protect staff and clients from violence. Organizational leadership was discussed by CHNs, but for the most part, they were not interviewed directly. One participant was in a leadership position but was in more of a staff supervisory role, still worked directly with clients, and they were not in an organizational leadership position (e.g., executive leadership team/board of directors). CHNs raised the issue of organizational leadership repeatedly throughout the interviews, and leadership emerged as a critical (dis)enabling element towards progress on truth and reconciliation and nursing actions.

CHNs were the main individuals under study within the situation, as this study sought to explore their nursing actions and perceptions about Indigenous homelessness. All of the interview participants worked in harm reduction nursing in some capacity. Discursive constructions of harm reduction nurses are thus important situational elements. Nurses' images and self-perceptions have frequently tended to revolve around the notion of nurses as self-sacrificing angels and also around notions of powerlessness within healthcare hierarchies and subservient to physicians, all of which are rooted in histories of colonialism and patriarchal

gender oppressions (Gill & Baker, 2021; Mendes et al., 2021; Stake-Doucet, 2020, 2023). However, the reality is far more nuanced and complex, as the previous chapter highlighted.

A notable intersection in the social world of harm reduction is social processes of controlling vices and the nurse as angel discourse. This relationship is held in tension within the social world of harm reduction. Difficult work and low pay suggest that some CHNs may be more likely to draw on elements of the angel narrative as a motivation for their work. For example, in my nursing practice, I have heard many comments that imply altruistic motivations such as "we're not doing it for the money" or that other nurses don't want to work in this practice area because we are exposed to profound amounts of social suffering and clients can be challenging to work with. Some of these motivations and values statements also emerged in interviews. However, harm reduction nurses were vilified at times in the media and by conservative politicians for perpetuating the opiate crisis, negating the image of nursing angels. For example, CHNs may provide access to safer supply opiates/stimulant drugs, and other supplies for using drugs more safely, which is construed as enabling people to use substances, rather than encouraging abstinence-based treatment and recovery. This illustrates some of the ways that CHNs may be working against settler colonial moral values and rejecting their role in controlling social vices. Therefore, tensions exist within CHNs harm reduction roles in seeking to control individual behaviours to ameliorate risk, while at the same time destigmatizing substance use and meeting people where they are at with their substance use.

Non-Human Actants. The visibility of certain non-human actants (e.g., encampments and drug paraphernalia, such as discarded used needles and crackpipes) are bound up with backlashes against harm reduction. Tents were discursively constructed in some media articles as a risk to the public; for example, as a fire hazard or as shelter for potentially violent people

experiencing mental illness and substance use, or criminals and drug dealers (e.g., Hamm, 2024; Sarkonak, 2024). Meanwhile, used needles and crack pipes found around encampments, shelters, and safe consumption sites were discursively constructed in the media and by politicians (e.g., Rob Ford, Pierre Poilievre) as immoral, dirty, vectors for disease, and representing risk to innocent bystanders such as children (Benzie, 2024b; Huston, 2024; Muschi, 2024). CHNs were involved in distributing needles and crackpipes; therefore, CHNs may be discursively bound to these non-human actants and CHNs themselves may be seen as posing a risk to society. Needle and crack pipe sharing represents significant risk of disease transmission, which harm reduction initiatives may successfully ameliorate through provision of supplies to use more safely (Colledge-Frisby et al., 2023; Stroffolini & Stroffolini, 2024).

Unfortunately, outrage around public risks from drug use debris is significantly driving current policy making to defund evidence-based harm reduction programs. Research suggested that needle exchange programs and SCS do not increase needle debris as they also offer opportunities to safely dispose of drug use supplies (Tung et al., 2023). In a recent scoping review, perceptions that safe disposal bins enabled drug use further limited the availability of opportunities to safely dispose of needles and crack pipes (Tung et al., 2023). Moreover, Tung et al., (2023) also found that people who use drugs typically do not want to discard used drug paraphernalia on the ground and need readily available and strategically placed disposal sites that allow for discrete use without public scorn and attention from law enforcement officers. Politicians should focus on the best available evidence to reduce needle debris, rather than letting stigma, moral judgments, and misperceptions drive policy making.

The concurrent housing and opiate crisis were key non-human actants, which were the principal focus of CHNs work. These crises were noted by CHNs as competing and conflicting

priorities to cultural safety, and Indigenous specific advocacy for their rights to equitable access to housing and healthcare free from discrimination. Other important non-human actants included things that increased nurses' workload such as COVID 19. EMRs and medical forms are also non-human actants that may at times increase workload, but that were also tools in CHNs systems navigation work. EMRs facilitate clinical knowledge sharing but may also be discursive sites where stigma and stereotypes are perpetuated and may bias care. For instance, labels such as "violent patient" or "risk of violence" may commonly be placed on EMRs of people experiencing substance use and homelessness. Labels may alert HCPs to potential risk of staff harm, but they typically follow people throughout care trajectories and may also bias care.

Intergenerational trauma emerged as a key non-human actant involved in Indigenous homelessness, which was discursively constructed by nurses as influencing health outcomes and healthcare access. Research has emphasized the many ways in which trauma can be passed down from parents to children, and also how historical trauma can affect future generations at the population and community level (Bombay et al., 2011, 2014; Starrs & Békés, 2024). For example, psychosocial stressors and exposure to trauma impact biological processes, including but not limited to, fetal development during pregnancy, and critical aspects of child development (Swales et al., 2023). Additionally, psychosocial stressors and discrimination (e.g., homelessness, racism, poverty, violence) increase allostatic loads and may lead to emergence of biological disease processes in individuals across their lifespan, thus influencing health outcomes (Miller et al., 2021). Intergenerational trauma was largely considered by CHNs, to be a uniquely Indigenous phenomenon, which they primarily connected to Indian Residential Schools and culture loss. Indigenous intergenerational trauma is distinct from other forms of trauma because it is rooted in histories of colonization (Bombay et al., 2014; Haskell & Randall, 2009).

Trauma, more generally speaking, was also an influential element in CHNs social worlds and nursing practices. Complex trauma, mental illness, substance use, poverty, intimate partner violence, and adverse childhood experiences such as child-welfare involvement and lack of support for children leaving foster care are direct pathways into homelessness among Canadians from all cultural backgrounds that are also linked to poor health outcomes (Guirguis-Younger et al., 2014; MacDonald & Cote, 2022). Therefore, trauma informed care (TIC) is a critical part of harm reduction nursing because substance use is interconnected with trauma. Undeniably, homelessness is a traumatic experience, and trauma is also a pathway into homelessness (Hopper et al., 2010; Kerber et al., 2020). However, a narrow focus on the direct pathways listed above may lead to incorrect assumptions that individuals or their families are to blame for their homelessness, because it ignores the ways that systemic factors (e.g., anti-Indigenous racism, gender discrimination, and lack of support for people with mental illness, cognitive impairments, and physical disabilities) leave people vulnerable to individual level risk factors (Alaazi et al., 2015; Anthony & Hohmann, 2024; Bono, 2019; Thistle, 2017). Systemic factors, including colonization, collectively create harmful social conditions that people must navigate often long before their individual choices or behaviours emplace them on a direct pathway towards homelessness (MacDonald & Cote, 2022; Schmidt et al., 2015). These systems level factors are the structural determinants of health and are upstream factors from the social determinants of health, which include lifestyle behaviours, and material and psychosocial circumstances (Etowa & Hyman, 2022; WHO, 2010). CHNs generally had strong understandings of both structural and social determinants of health in relation to homelessness and substance use.

Trauma and substance use also impact client capacity, which was raised by CHNs as influencing the level of involvement that people had in their own care, and the kinds of intensive

support that they required from CHNs. For example, trauma and substance use influence memory, executive functioning, and impulse control (Narvaez et al., 2012). Additionally, traumatic brain injuries (TBI) are not uncommon among people experiencing homelessness from violent assaults, exposure to toxic drugs, and hypoxia that often occurs during overdoses. TBI are also a known risk factor for homelessness (Hwang et al., 2008; Monsour et al., 2023). People experiencing child abuse and/or intimate partner violence, experience high rates of TBI from abuse and they are also at greater risk of their TBI going untreated because their abusers may deter access to healthcare (Iverson et al., 2019; Narang et al., 2020). TBI may have important, and yet often unacknowledged, impacts on people's capacity for a full recovery from substance use and their ability to participate in traditional abstinence based rehabilitation programs; furthermore, TBI may also impact success in independent housing and employment among people experiencing homelessness (Chan et al., 2023; Stubbs et al., 2020).

Key Concepts/Ideas. A number of key concepts emerged as particularly relevant to the situation. Harm reduction is the practice area among CHNs that participated in interviews, and harm reduction and TIC emerged in interviews as important philosophies of care with people experiencing homelessness. Some key concepts were identified at the proposal stage (e.g., relational ethics, racism, colonialism, and oppression) and they formed part of the theoretical framework and research questions. Other key concepts, including cultural safety, cultural competency and social justice, emerged during reviews of nursing websites, nursing documents and the TRC Calls to Action. Cultural approaches were highlighted in RN practice guidelines to inform curricula and guide all nursing practices. Conceptual confusion regarding cultural safety and cultural competency among CHNs emphasized a need to focus less on abstract concepts, and to focus more on specific nursing actions against intersecting oppressions.

Nursing Action. Relational practices that emerged as important anti-oppressive work among CHNs included narrative elicitation (e.g., sharing stories, building rapport), bearing witness to clients' lived experiences, suspending judgment, and shared decision making. These relational practices were described by CHNs as requiring considerable time, intentional effort, and emotional investments. Importantly, relational practices and anti-oppressive actions are invisible work compared to the more visible tasks of nursing (e.g., woundcare, giving injections) and invisibility has implications for recognition of these actions by decision makers, leaders, and funders. Anti-oppressive actions that were described as "behind-the-scenes" included advocacy, systems navigation and care coordination. Advocacy was sometimes undertaken at organizational levels, but rarely at a systems level. Individual level advocacy against discrimination sometimes took place in the moment during client encounters, for example with first responders, but mostly advocacy was behind-the-scenes communication to ensure clients received appropriate care from other service providers and access to healthcare, housing, and other supports.

Regulatory and Legal Elements. Regulatory and legal elements included elements that should guide CHNs anti-oppressive actions, such as policies and practices endorsed by their regulatory college (i.e., CNO), the TRC Calls to Action, and UNDRIP. I also included the CNA's *Code of Ethics For Registered Nurses* (2017) and the CNO's (2023) recently revised *Code of Conduct For Nurses* as regulatory and legal elements that guide practice. Nursing ethics must commit to uphold health as a human right and to uphold UNDRIP, which was codified into Canadian federal law and received Royal Assent on June 21, 2021. Human rights legislation includes the 1948 *United Nations Universal Declaration on Human Rights* (UDHR) and the 1982 *Canadian Charter of Rights and Freedoms* (Charter). Provincial conservative politicians (including Ontario's current Premier, Doug Ford), with increasing frequency, have invoked the

"notwithstanding clause" of the Charter to avoid legal challenges to their proposed legislation. Thus, policies that might otherwise be challenged on the basis of discrimination or human rights violations are passed, and the "notwithstanding clause" allows politicians to evade judicial oversite of contentious policies for 5 years. Health Canada and enforcement of the *Controlled Drugs and Substances Act* (1996) is another regulatory/legal element that influenced CHNs' harm reduction work including safer supply programs and legal operation of SCS. Law enforcement officers and their enforcement of criminal codes and municipal bylaws around loitering, trespassing, panning, and substance use, also intersected with CHNs work as noted on the social worlds and arenas map (Figure 4.1). Finally, organizational policies and oversight are regulatory elements that exerted considerable influence over CHNs' practices.

Silent/Implicated Actors. Implicated actors may be physically present in the situation, but are silenced or ignored, and their interests are made invisible by more powerful actors (Clarke et al., 2016). Implicated actors may also be solely discursively constructed by others and not physically present in the situation (Clarke et al., 2016). For example, people who use substances are implicated actors that are discursively constructed, with regards to harm reduction debates, but rarely physically present in the arena of federal and provincial politics. Indigenous persons living with homelessness are also implicated/silent actors who are physically present in the health and social services arena, but they rarely have a voice in the services that impact them, partially related to paternalistic attitudes among more powerful actors (e.g., policy and decision makers, HCPs). Indigenous people experiencing homelessness were discursively constructed by CHNs within interviews, which I describe in more detail in this chapter. Joyce Eschequan is also an implicated actor whose death prompted public outcry and brought greater attention to racism in nursing. Details of her death were made public and widely circulated in national news media

outlets. The discourses surrounding her death helped illustrate how racism in healthcare is socially constructed as a problem among a few bad apples, and systemic racism is denied.

Acute care nurses were not physically present in community healthcare arenas; however, they were discursively constructed by CHNs as actors that perpetuated discrimination against CHNs' harm reduction clients when they needed to go to hospitals, and deterred access to healthcare among Indigenous people experiencing homelessness. Acute care nurses were also constructed by CHNs as stretched thin by staffing shortages and the increased demands during and after the COVID 19 pandemic. CHNs perceived acute care nurses to be lacking in time and capacity for anti-oppression work and advocacy. Research has found that nurses historically have not had a voice in their own media representations, and that they are discursively constructed by others (e.g., journalists, physicians, politicians) and while they are at times portrayed positively by media their concerns about working conditions and compensation were often ignored, including during the COVID 19 pandemic (Gill & Baker, 2021; González et al., 2023; Lynch et al., 2021; Mason et al., 2018). This lack of voice further positions nurses, more generally, as silent/implicated actors. However, one study suggested that nurses were exerting more agency and influence over media narratives during COVID and were often savvy in their use of social media to influence mainstream media (Gagnon & Perron, 2020a).

I did not position CHNs as silent or implicated actors because they do have power and influence within their social worlds and healthcare arenas. However, there were examples in the media where politicians and newsmakers attempted to silence, often through ridicule, nurses who advocated for harm reduction and/or advocated for human rights of marginalized people (e.g., people who use drugs, and/or who are homeless and/or who have mental illness, Cosh, 2024; Skamski, 2024). CHNs described times when their advocacy efforts were ignored and/or that

they were not brought into decision making processes within their own organizations, let alone within any level of government, which could further position them as silent/implicated actors.

Circulating Discourses. Public perceptions, political discourses, and circulating discourses in news media were discussed at length in the previous chapter. Specifically, I note that two seemingly disparate discourses, the first that denied systemic racism in healthcare and the second that perpetuated backlash against harm reduction programs and nursing practices emerged from similar worldviews and social processes bound up with colonialism and White supremacy. Indigenous Peoples were not often discussed in news media in relation to substance use or homelessness, despite the racial inequities in rates of homelessness (Challand, 2023; Johnston, 2020). Instead, racially coded language (e.g., street addict versus middle class or suburban) has largely replaced overt racism in more formal discourses, including in news media, political statements, and even within public health and anti-stigma campaigns (Dertadian & Rance, 2023; Johnston, 2020; Kohm & Maier, 2023; Neufeld, 2023).Therefore, racially coded language may obscure the various racisms underlying current harm reduction backlashes that influenced policy making in the realm of homelessness and substance use. However, more overt stigma and stereotypes about Indigenous Peoples continue to circulate informally including in hospital hallways and amongst settler friends and families.

Discursive Constructions of the Situation

In the next sections, I focus on discursive constructions of the situation and I introduce the third type of situational analysis maps (positional maps) that illustrate some of the positions taken in data as well as relative silences. Following this, I describe discursive constructions of the situation that emerged in interviews, beginning with a fulsome analysis of CHNs discursive constructions of Indigenous homelessness and some key issues and concerns raised by CHNs.

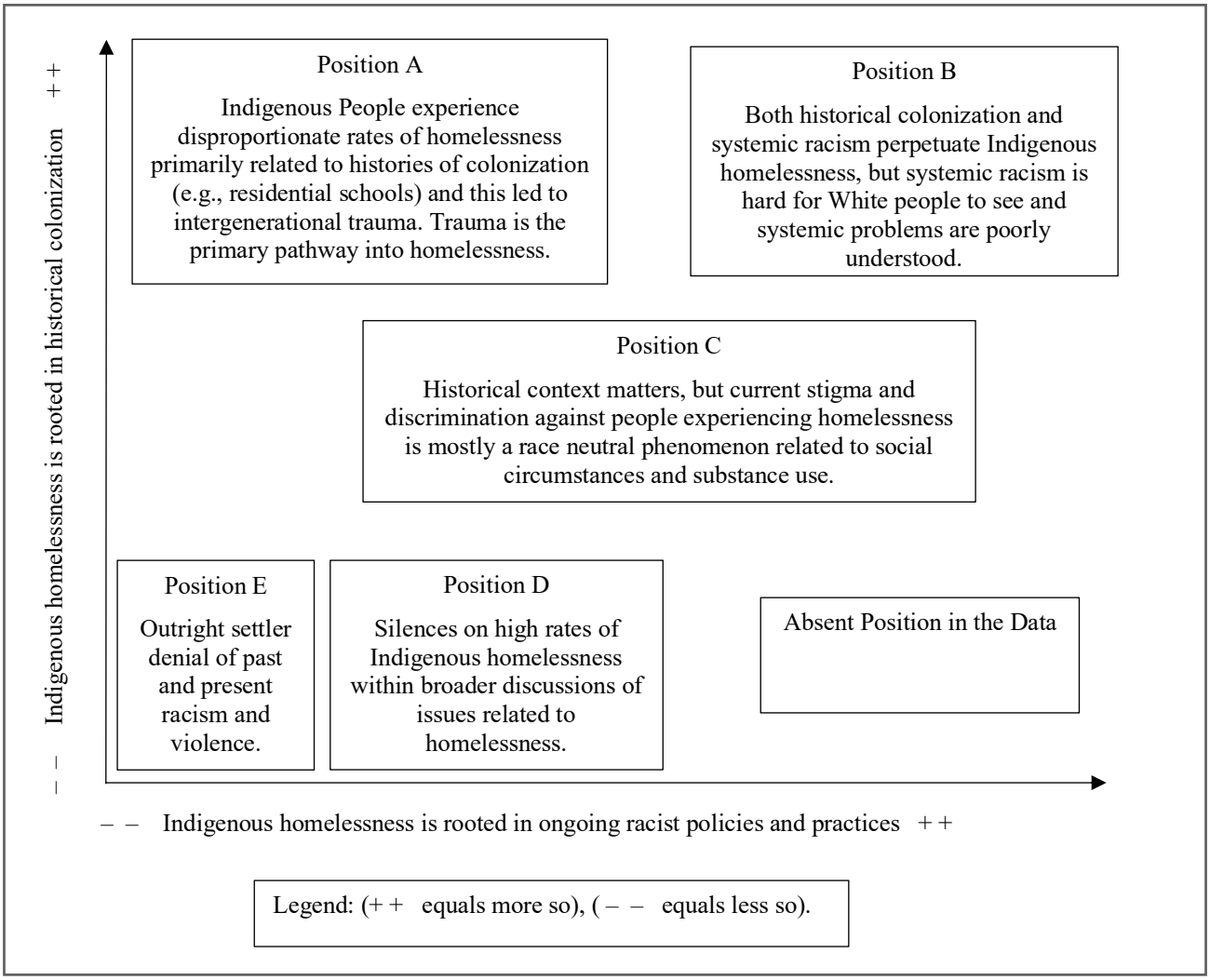
Positional Mapping

Clarke et al. (2018) suggested that positional mapping is an important analytic process and noted that the "core goal of positional maps is to lay out the major positions taken on issues in the situation… and often but not always contestation" (p. 165). Importantly, positions are not necessarily attached to a single person, nor are they a dominant position taken within one social world. Discursive positions do not represent any one individual actor or collective actors and one must move "beyond the knowing subject," even a single individual and most certainly groups of people "may and commonly do hold multiple and often contradictory positions on the same issues" (Clarke et al., 2018, p. 166). One of the more interesting positions that emerged within the interview data and diverged among participants, and even within a single interview was whether to locate the problem of Indigenous homelessness as primarily temporally/historically or primarily systemically/structurally. Figure 4.3 maps these divergent positions on the situation.

I noted various nuanced combinations of the problem as one of historical trauma rooted in colonization, and/or the problem as one of present-day racist policies and systems. The positions identified within Figure 4.3 clearly illustrated how high rates of Indigenous homelessness could primarily be conceptualized as rooted in historical processes/events that are no longer ongoing versus the more insidious and invisibilized nature of systemic racism in current social practices/policies. From a historical perspective, ongoing discrimination against Indigenous people who are homeless could be perceived as more race neutral and instead relate to social class and people's substance using behaviours and street involvement. From a systemic racism perspective current structures and systems are critically important causes of Indigenous homelessness, but the racism inherent to these systems are more insidious and covert.

Figure 4.3

Positional Map: Discursive Positions Locating Indigenous Homelessness Temporally Versus Systemically and Structurally



The problem of high rates of Indigenous homelessness was virtually always contextualized within histories of colonization in any discourse that specifically referenced Indigenous homelessness, and this is reflected in positions A, B and C on the map (Figure 4.3). Indigenous homelessness was not conceptualized as solely a structural/systemic problem, nor is this a likely position to emerge in data even if I were to conduct many more interviews; therefore, this is an absent position. There were media articles that presented discourses of

outright settler denial of any past wrongdoing, which maintains that colonial practices and policies were benevolent attempts to help Indigenous people. Settler denial discourses argue that many Indigenous people even had positive experiences with Indian Residential Schools and also deny that systemic racism against Indigenous Peoples has ever existed now or in the past. These discourses, found solely in the media and not in CHN interviews, are represented by position E. CHNs all acknowledged high rates of Indigenous homelessness, but this disparity was often omitted in media articles about harm reduction and homelessness more generally, and this silence is represented by position D on the map. Many CHNs expressed that systemic racism exists, but noted how challenging it could be to see and respond to current problems of anti-Indigenous racism in social systems, represented by position B. Therefore, despite an acknowledgment of systemic problems by virtually all CHNs, some CHNs felt problems of stigma related to homelessness and substance use were largely race neutral, represented by position C, and this position further suggested that discrimination experienced in healthcare and other services, similarly impacted all of their clients regardless of race.

Intergenerational trauma, which was positioned as a uniquely Indigenous phenomenon, connected historical events related to colonization to current problems and manifestations of harm, including the concurrent problems of substance use and homelessness. This historical perspective is represented by position A. Problematizing the discourse of intergenerational trauma is not intended to minimize the importance of understanding impacts of various forms of trauma on the physical and mental health of families and people across time. The impact of intergenerational trauma is backed by scientific evidence (Bombay et al., 2011, 2014; Starrs & Békés, 2024), which I described in my relational ecological overview. Indigenous specific traumas are an important area of study within health sciences and nursing research. Additionally,

trauma informed perspectives may help to position the problem of substance use among Indigenous Peoples in less stigmatizing ways.

The problem arises when intergenerational trauma locates past problems within the psyches and bodies of Indigenous Peoples living today; thereby, intentionally or inadvertently, minimizing present day problems of ongoing racism, structural violence, and systemic oppressions as a source of harm (Tuck & Yang, 2014). Centering of intergenerational trauma and historical events within discourses about homelessness, may obscure problems related to colonialism and systemic racism within settler society and Canadian institutions that are still ongoing today. Additionally, damage centric discourses highlight death, disease and disability among Indigenous Peoples, while simultaneously minimizing their strengths, resiliency and capacity for self-determination. Therefore, trauma may be used to deny Indigenous sovereignty (Tuck, 2009; Tuck & Yang, 2014). Additionally, use of racially coded language is more covert than blatant anti-Indigenous stigma and stereotypes, nonetheless racially coded language in media may influence policy making and nursing practices, and thus these seemingly race neutral stigmas perpetuate systemic racial harm (Jiwani, 2009; Johnston, 2020; McCallum & Waller, 2017; Nairn et al., 2011; Nelson et al., 2016). CHNs did not raise the issue that racially coded language was used in discourses about substance use and homelessness that were circulating in the media around the time of the interviews, and CHNs also had a very difficult time teasing out how prejudice and discrimination manifested differently against their Indigenous clients compared to White settler clients.

CHNs Discursive Constructions of Indigenous Homelessness

All of the CHNs acknowledged that Indigenous Peoples are disproportionately affected by homelessness consistent with point-in-time counts described in previous chapters. One CHN

described it as “wildly high compared to the actual percentage of Indigenous folks in the general population” (CHN8). All of the CHNs attributed this disparity primarily to intergenerational trauma from historical aspects of colonization. The problem of stolen land was a relative silence in relation to Indigenous homelessness. CHNs were also very hesitant to introduce the problem of substance use into their discussions of Indigenous homelessness. Discrimination related to substance use and street involved behaviours were typically viewed as a race neutral problem. Clients’ capacity to engage in self-care and express their health-related needs also formed part of the discursive constructions of Indigenous homelessness. Reduced capacity and mistrust were framed as a challenge among their clients of all racial backgrounds, but that this was exacerbated for Indigenous clients by past experiences of racism and harm from settler colonial systems and HCPs. Indigenous culture was held in high regard by CHNs, and culture was perceived to be an important pathway to support healing and well-being among their Indigenous clients. Next, I will discuss each of these key elements (culture, trauma, stolen land, substance use, and capacity) that emerged in interviews and how these elements were discursively constructed by CHNs.

Culture. CHNs all voiced positive views about Indigenous cultures and viewed culture as an important pathway towards healing traumas and other harms associated with colonization. Culture was viewed as important for recovery from substance use disorders and mental distress among Indigenous clients experiencing homelessness. One participant described how working in harm reduction and experiencing overdose deaths that

> we've also been able to implement their culture into our practices, like, with all the grief we experience here, we've had smudging, sharing circles, the sacred fire, pipe burning, passing ceremonies. So yeah, we've been able to learn from one another, which is amazing. (CHN3)

Most of the CHNs highlighted that having cultural programming at their organizations was beneficial to staff and clients alike, and that participating in cultural supports alongside clients was an opportunity to foster relationships with clients and engage in mutual learning.

CHNs also raised the problem of making assumptions about culture based on their limited knowledge about Indigenous cultures. Some commonly held assumptions that CHNs raised during the interviews included assumptions that all Indigenous people would want to engage in cultural practices or ceremonies, a lack of awareness of Indigenous diversity and different cultures, pan-Indigenous approaches to incorporating culture, and privileging Western medicine. The next quote highlights how this particular CHN became aware of their assumptions about whether and how Indigenous clients would want to engage in cultural practices or not. “I had gotten in a place before where I would make assumptions that all Indigenous clients would want to [participate in cultural practices] and I learned very quickly that’s absolutely not the case… I try to just ask questions” (CHN8). It also highlights the potential problem of pan-Indigenous approaches when nurses might not know or understand different worldviews and practices among different Indigenous groups. For instance, smudging or sweat lodges are specifically First Nations’ cultural practices that Inuit may or may not want to participate in because they were not traditionally part of their cultural practices.

Trauma. During the interviews, CHNs all demonstrated a strong awareness of structural determinants of health consistent with extant literature described earlier. Victim blaming and other discourses about Indigenous Peoples wrapped up with individualism were also notably absent in CHNs discussions of Indigenous homelessness. Additionally, given CHNs awareness of linkages between trauma and substance use, and given their trauma informed approaches to harm reduction nursing practices, it was not surprising that CHNs discursive constructions of

Indigenous homelessness revolved around trauma. In particular, CHNs all highlighted the problem of intergenerational trauma from Indigenous families' residential school experiences.

CHNs suggested that traumatic experiences rooted in histories of colonization differentiated Indigenous homelessness from the kinds of traumas that were pathways into homelessness among people of all racial and cultural backgrounds. One CHN described the problem of historical trauma being passed down: "maybe the clients I'm seeing haven't firsthand gone through, but again parents and… you know that generational trauma, it can be passed down to them, which could be exacerbating what's going on with them presently" (CHN 10). This historical lens, which draws attention to historical injustices was critically important to CHNs' understandings of the situation and was exemplified in the following quote:

> I think there's a lot of stereotypes still, even though we've had a lot more knowledge in regard to what actually happened with colonialism and with the residential schools and the Sixties Scoop. Now it's starting to come out… there's still a lot of people that don't hold that knowledge and so therefore they just understand the stereotypes that have been there for a long time… that they have addictions, they don't work hard, they're you know beating the tax system, you know, but I think if you understand the history and where they're coming from then you don't have those mindsets… but I think a lot of the oppression comes from lack of knowledge and kind of like our government withholding the information for so many years. (CHN3)

Indian Residential Schools have received considerable media attention since the TRC's public hearings, and additional media attention more recently arose with the discoveries of unmarked graves at former residential school sites. The TRC and media attention on residential schools likely contributed to CHNs focus on histories of state sanctioned child apprehension. However,

Indian Residential Schools and the Sixties Scoop are examples among many violent policies and practices of settler colonialism consistent with genocide (MMIWG, 2019a). A narrow focus on historical injustices and intergenerational trauma may detract from understanding ongoing racism and colonialism. Settler nurses may focus on historical injustices to deflect from their complicity with systemic racism and the ways in which nurses uphold colonialism. This deflection moves from assuming personal responsibilities towards blaming governments and previous generations of settlers. The ease with which CHNs connected residential schools to Indigenous homelessness was in stark contrast to the problem of stolen land.

Stolen Land. The relationship between stolen land and Indigenous homelessness were more tenuous discussions and relative silences among CHNs in the interviews, despite that land loss arguably has a more direct connection to being homeless than residential schools. CHNs highlighted the problem of land loss with the less controversial language of displacement from home communities and noted that migration to urban centers through medical travel resulted in Indigenous homelessness. However, they tended to avoid explicit mention of stolen land. The following quote exemplifies some of the avoidance of making more explicit connections between stolen land and Indigenous homelessness. “There’s also a lot of people who are displaced, a lot of folks are kind of in [name of city], but that’s not their home or that’s not where their supports… or their culture is” (CHN7). Another CHN drew attention to land, but in a way that inadvertently minimized urban land claims when they problematized how few Indigenous HCPs were in positions of power in remote communities, they commented “it's so weird seeing it actually in the community, because you're in a place that is like, literally Indigenous land” (CHN1), which implied land outside of reserves is not Indigenous land. A CHN that immigrated

to Canada as an adult was one of the few to explicitly make the connection that Indigenous people experiencing homelessness were actually the “landowners” (CHN6).

Many land claims remain unresolved and much stolen land has never been returned to Indigenous Peoples; therefore, this settler colonial injustice is not simply located in the past, it is ongoing today and likely will be for many years to come (Atleo & Boron, 2022; Spear Chief-Morris, 2020). Moreover, acknowledging stolen land carries with it potential implications for settler landowners and Canadian taxpayers in the form of financial retributions for stolen land; therefore, land back movements could result in some redistribution of settlers’ intergenerational accumulations of wealth (Atleo & Boron, 2022; Spear Chief-Morris, 2020). The notion of land back tends to be a contentious issue and triggers a lot of defensiveness and backlash among settler Canadians and in mainstream media. One CHN echoed this point:

> I think the land stuff, I believe in it, yes. Yet, also I really struggle with it as a colonial settler whose family owns land now, of like, how would that actually look? There is a part of me that feels really like [long pause], I don't know how that gets done without a whole bunch of people getting hurt and angry. How to make that right? (CHN5)

Silences around land and Indigenous homelessness were not surprising. I know for myself, as a White settler, that making the connections between urban Indigenous homelessness and stolen land requires an uncomfortable acknowledgement of my ongoing complicity with homelessness. Settlers can largely distance themselves from the atrocities of residential schools and past actions of the state in ways that cannot be avoided with questions of land rights and restoring Indigenous sovereignty in the future, particularly in urban areas where CHNs were living and working at the time of the interviews. Settler centric narratives about reconciliation in the media, and within

government statements, also tend to avoid the issues of land and instead focuses on residential schools as the primary harm related to colonization and firmly locate this problem in the past.

Substance Use. In my research proposal, I acknowledged that substance use was a salient issue among people experiencing homelessness, but I did not want the stigma of substance use to overshadow the problems of anti-Indigenous racism and Indigenous homelessness. It was also not my intention to only focus on harm reduction nurses and I did not ask specific questions about substance use in the interviews. During the interviews, participants, like myself, were also guarded on the topic of drugs and alcohol and sought to avoid making explicit connections between Indigenous homelessness and people's substance use. Therefore, some of the silences in the data around substance use were co-constructed between myself, as the researcher, and the interview participants. Despite that I didn't ask questions about substance use, my open-ended questions allowed ample opportunities for CHNs to introduce the topic. These silences could also be viewed as pushing back against commonly held racist stereotypes about drug and alcohol addictions among Indigenous Peoples that cause immense harm in healthcare. CHNs' hesitations to discuss substance use were interesting given that their organizations' harm reduction mandates revolved around serving people who use substances. Therefore, as the study progressed it became apparent that I needed to look more closely at the elephant in the room. Race has no bearing on substance use—racism, homelessness, and substance use are deeply intertwined.

The relationship between trauma, colonization, and substance use within Indigenous communities is widely acknowledged in health research and by the CHN participants in this study. CHNs also noted that discrimination against their Indigenous clients was still "very systemic" albeit more invisible into today. However, CHNs also tended to frame stigma and structural violence related to substance use as a race neutral problem, which suggested that on

some level CHNs may have lacked recognition or awareness of the systemic racism inherent within the so called “war on drugs” and colonial drug and alcohol policies discussed in the previous chapter. Drug and alcohol policies were often overtly racist in the past. This racism persists today in public perceptions and government policies and practices, although it is cloaked in racially coded language. However, racist outcomes remain the same, including decreased access to care, and higher rates of morbidity, mortality, poverty, homelessness, and incarceration for drug and alcohol related offences among Indigenous populations compared to the overall population of people in Canada (Fowle, 2022; Jongbloed et al., 2017; Marshall, 2015).

CHNs were also very careful not to suggest that substance use was any more prevalent among Indigenous people experiencing homelessness compared to non-Indigenous people experiencing homelessness. However, statistics based on point-in-time counts suggested that Indigenous people experiencing homelessness are more likely to report substances use problems and were also more likely to report physical and mental health concerns compared to the overall population experiencing homelessness (Government of Canada, 2023). Reduced access to healthcare due to racism may influence substance use patterns because people may self-medicate when mental and physical pain goes untreated (Nelson et al., 2016; Wardman & Quantz, 2006). Importantly, statistics must be connected to racism and colonialism. Higher reported rates of substance use do not suggest that Indigenous people have innate tendencies towards addictions, nor is Indigenous culture part of the problem (Marsh et al., 2015; Smye et al., 2023). Relevant to my study, point-in-time statistics simply highlight the importance of equitable access to harm reduction care, and the need to collect race-based data to evaluate harm reduction programs.

Additionally, Indigenous clients probably do not experience discrimination related to their homelessness and substance use as a race neutral phenomenon, given the ways in which

racist stereotypes about Indigenous Peoples have often revolved around substance use, street entrenched poverty, and overuse of tax funded social services (Bucharski et al., 2006; McCallum et al., 2021; Nelson et al., 2016). In the previous chapter, I explicated the ways in which systemic racism and substance use are clearly intertwined, and how insidious racially coded language has replaced overt racism in media and political discussions. Therefore, the perception among CHNs that discrimination and stigma related to substance use was race neutral, and the ways in which CHNs acknowledged problems were systemic but struggled to identify how racism manifested against their Indigenous clients in current policies and healthcare practices is a potential knowledge gap that needs to be addressed in harm reduction nursing.

Client Capacity. One of the ways that discourses about trauma and substance use intersected was in CHNs perceptions about the reduced capacity for their clients to engage in their own care and their (in)abilities to navigate healthcare and other social systems and advocate for themselves. Discourses around trauma and/or substance use also have the potential to be damage centric, minimize client strengths, and downplay client capacity to care for themselves. Trauma and damage centric discourses also risks slippage into White benevolence and paternalistic racism. Slippage into White benevolence was evident on close examination of interview data. For example, CHNs made statements about Indigenous clients not knowing what they needed or not knowing how to ask for the things they needed, which they felt decreased their access to care. One CHN described how cultural identities had been

> kind of wiped away and assimilated. So, in a way we don't even know how to relate well to them, and they don't even sometimes know what they need because it was deprived of them from such a young age. (CHN3)

Another CHN commented about children being denied care in residential schools and foster care: "poor teeth? Well, it's not from today…all this hygiene and all these basic things that we take for granted. Maybe they were never taught, or somebody else taught them" (CHN9). Although well intentioned, these kinds of narratives have been weaponized by settlers in the past and into the present day to justify paternalistic interventions into the lives of Indigenous families and to deny sovereignty among Indigenous communities/nations (Tuck, 2009). One CHN described that at times paternalistic racism had emerged when clients rejected westernized medicine in favor of healing approaches rooted in their own Indigenous cultures.

> It's this very narrow box of westernized medicine and it almost became a tense encounter… you're refusing… a little bit of shaming almost of, you're not helping yourself or you're not buying into healthcare to get well and it's challenging because that person will identify that that's not the care and the wellness that they needed. (CHN8)

Therefore, before assessing client capacity to make their own decisions, settler HCPs must carefully assess their own biases about healthcare and healing, which may be rooted in White supremacy, White benevolence, and paternalistic racism. Settlers must not make assumptions that Western healthcare systems are acting in the best interests of all clients, meeting all of their clients' needs, and/or are supporting client's cultural beliefs.

The paternalistic assumptions about trauma described above and the problem of underestimating client strengths were noted by a few participants. One participant described how

> I really have to be careful because a lot of times people are a lot more resilient and a lot smarter and a lot more connected than sometimes nurses give them credit for. Right?... you've survived this long through these, wild, unspeakable things that I can't imagine and you're still able to function… So you've clearly got some skills, you've clearly got some

> resources… how can I help you? … Because there are things… that they absolutely do not want, that are kind of tokenistic, that aren't actually helpful, that you think are helpful. So… I'm not going to make assumptions about what you need. (CHN1)

Another CHN described their shifts in thinking over time. They described how knowledge of trauma was a critical part of their ability to suspend judgment of people experiencing substance use and that it reduced the problem of racist stereotyping. However, they also noted that assumptions about trauma may be problematic in many of the same ways described above and that they were working towards not making assumptions.

> I definitely had some weird beliefs that were obviously false… but now I think I'm in another place where I have to also not assume that just because someone is Indigenous it doesn't mean that they have childhood trauma… I think I need to work towards having a more neutral view or just not making assumptions in general. (CHN7)

Although, TIC is intended to be strength based, by virtue of its primary focus on the problem of trauma, TIC risks deficit-based discourses. This inconsistency between the strength-based principles of TIC and deficit-based practices are also highlighted as problematic in the literature (Ginwright, 2018; Palma et al., 2024; Varcoe et al., 2016). Aside from the instances described above, the issue of client capacity was not raised by CHNs as an Indigenous specific issue and capacity was constructed as unrelated to race.

The discursive construction of people experiencing homelessness having reduced capacity emerged mostly in response to questions about involving people with lived experience in advocacy and clients' abilities to participate in their own healthcare. Although it can be highly problematic to make assumptions about client capacity based on trauma and substance use, both of these health concerns do have actual impacts on cognitive abilities as discussed previously.

The problem of client capacity among all clients (Indigenous or not) was raised by CHNs as a barrier to involving their clients in care coordination, systems navigation, and advocacy efforts, which often resulted in doing *for*, rather than doing *with*. Many CHNs had not considered how they might do advocacy *with* rather than advocacy *for* and the question prompted reflection.

> Like with them alongside us?... that's a really interesting question. A lot of the times I am actually behind-the-scenes, not with them… I never really thought about that… just the time I think is kind of a barrier… they struggle with reliability in an appointment setting, you know. So I would have to really have an empty day I think if I was going to advocate with them. (CHN3)

CHNs acknowledged the importance of involving people with lived experience in advocacy and within organizational decision-making circles. However, they also identified that in practice, there were numerous barriers to involving clients. Barriers to engage clients in advocacy, and/or organizational decision making included an inability to attend meetings regularly and on time because of meeting basic needs to survive, lack of interest, low literacy and internet barriers, attention deficits related to substance use, and power imbalances to have their voices heard. All of these issues were not seen as individual defects that should preclude people from their involvement, but rather as structural barriers that organizations and CHNs should solve. CHNs identified organizational, systemic, and structural issues within their social worlds and broader arena of healthcare, and I turn to these issues next.

CHNs Discursive Constructions of Key Issues and Other Situational Elements

In the following sections, I discuss situational challenges that CHNs identified within their own social worlds that specifically related to access to care. I have organized these

challenges into two broad areas, 1) accessibility of cultural supports, and 2) inequitable access to harm reduction care among Indigenous people experiencing homelessness.

Accessibility of Cultural Supports. A number of CHNs described a lack of cultural supports at their harm reduction organizations related to internal barriers. One CHN that participated on her own time described that she didn't feel leadership prioritized Indigenous cultural services, and notably this organization had declined to participate because they felt they didn't serve many Indigenous clients. "Okay we have a lot of support for newcomers, LGBTQ but… there's nothing here for Indigenous… and making them feel welcome. They do exist in …our catchment [area]" (CHN2). CHNs that worked for an organization that had brought in Indigenous healers and made country food available also described the challenges for clients to access traditional and land-based healing and suggested that "there was still a lot of work to do" (CHN6). Non-Indigenous organizations tended to offer the majority of harm reduction services in the city such as SCS and safer supply. Therefore, leadership and funders of CHCs should not assume that Indigenous cultural supports should be the sole domain of Indigenous specific health centers. Some CHCs' websites mentioned supports for newcomers and LGBTQ+, but none of the CHN's organizations mentioned Indigenous supports on their websites. This gap on CHC websites, also supported CHNs perspectives that some of their organizations were not prioritizing Indigenous programing.

Status Cards. Status cards were raised as a barrier to access cultural supports and NIHB coverage. One of the CHNs described status cards as a particular barrier to cultural supports.

> We had this drop in they would make food and Indigenous folks could just drop in… so it stopped during the pandemic and when it reopened, I guess their funding had changed

> and so people needed to present status cards in order to participate. A lot of people don't have that… and they wouldn't let anyone else in. So yeah, that ended. (CHN7)

This same CHN highlighted that their organization has a low barrier ID program but that their ID program was unable to assist with status cards. They noted that their CHC

> doesn't really help people get a status card, there's just a lot of missed opportunities to kind of do a little bit more, like sure people are walking through the door and of course they can get health care… but that's kind of where the bar has been set. (CHN7)

Importantly, status cards are a colonial invention bound up with the inherently racist *Indian Act*. When the Canadian government's Indigenous Services restricts funding for organizations to provide cultural supports on the basis of status cards this exemplifies structural violence, ongoing colonialism, and systemic racism. Further, it could easily be argued that controlling access to Indigenous cultural supports on the basis of a person's legal status under the *Indian Act* furthers an assimilationist agenda in health policy because those without status are denied access to (re)connect with cultural and community supports that promote health.

Non-Insured Health Benefits (NIHB). For status First Nations and Inuit, federal drug coverage is provided by Canada's Indigenous Services' NIHB program. Therefore, status cards and "n-numbers" are requisite to access additional healthcare funding (Graham et al., 2023). A lack of personal and financial documents were also barriers to drug coverage; income supports and finding housing among all clients regardless of race. Client belongings including ID and other paperwork often go missing or are stolen during encampment sweeps or in the shelter when clients are limited in how much they can bring with them and also face restrictions on keeping belongings on their person. However, being disconnected from family in remote communities could exacerbate the problem of getting copies of birth certificates or 'proving' their Indigenous

identify to obtain status cards. A lot of clients had difficulty obtaining status cards "because they no longer have connections to their families and their home bands and have a lot of shame to make those calls is what they had verbalized" (CHN8). Most CHNs also expressed that both themselves and social workers at their organizations had a lack of knowledge around status cards and NIHB and that this was at times a barrier or caused unnecessary delays in obtaining drug coverage. They described that the goal was often to apply for ODSP/OW to obtain Ontario drug benefit (ODB) coverage and avoid challenges of NIHB coverage altogether. Many CHNs were unaware of other health benefits that were included with NIHB (e.g., psychotherapy, medical devices), which may have resulted in missed opportunities to access additional support. NIHB was an area that CHNs desired additional training to better support their Indigenous clients.

Tensions with Harm Reduction. Some CHNs observed that tensions existed between harm reduction and some Indigenous service providers offering cultural supports/services. For example, a CHN described having Elders come in that "were very abstinence based and actually really shamed our clients because they were using substances" (CHN5). They described that their organization now offered cultural supports from a harm reduction focused Indigenous healer that another CHN from the same organization described as "avant-garde" in her approach. CHNs highlighted the importance of engaging harm reduction focused Indigenous healers and Elders that were open to meeting clients where they were at in their own cultural journeys and struggles with substance use. One CHN connected negative attitudes about substance use among some Indigenous service providers to problems of colonization. Some Indigenous organizations may promote abstinence to combat negative stereotypes about all Indigenous Peoples being 'drunks' or 'addicts.' As described earlier, these negative stereotypes were perpetuated by colonizers and settlers to justify paternalistic control over Indigenous Peoples and deny them rights to govern

over their own territories. Families might distance themselves from people who use substances because of these same stereotypes, but also because of the pain and trauma that can occur among families of all racial backgrounds as a result of problematic behaviours related to substance use.

Tensions between harm reduction and Indigenous cultural services had at times meant that CHN's organizations had discontinued their on-site cultural programing and instead would need to refer clients to Indigenous specific health organizations to access cultural programming. However, CHNs questioned whether Indigenous specific health organizations offered the same supports for harm reduction services. A CHN described an Indigenous drop in at their CHC.

> They would make food and all this lovely welcome space, but… no one was welcome to go if they were intoxicated… and we ended up discontinuing that service at our center because it was very contradictory to what our harm reduction role was. (CHN4)

Another CHN described struggling to support an Indigenous client to access culturally meaningful care and the tensions between substance use.

> It's really hard… I'll use his words [he] 'no longer wanted White man's medicine'… [he] was coming here seeking care because he was unwell… and he wasn't comfortable going to [name of Indigenous health center] because he wanted to present there abstinent and not intoxicated from substances. (CHN8)

Potential outcomes of these tensions between harm reduction and Indigenous cultural supports included fragmented care and a lack of wrap around supports for Indigenous clients who were not ready to be abstinent and preferred a harm reduction model of care, but who still desired to engage with healing practices that were culturally meaningful to them. CHNs described the importance of having harm reduction focused Elders, Indigenous healers and cultural

programming that was inclusive of people who use substances and that accessing cultural supports was meaningful for many clients.

Medical travel. Medical travel into the city and difficulties to return home, and lack of funding and supports for people leaving rural and remote communities were raised by CHNs as a potential pathway into homelessness. CHNs also suggested that sometimes Indigenous people from remote communities that were accessing healthcare in the city were inappropriately sent by first responders to homeless shelters when they were found in need of support, rather than more appropriately returning them to medical travel boarding homes or hotels where they were staying. Some CHNs blamed racism of police and other service providers for these inappropriate drop offs based on racist assumptions that all Indigenous individuals regardless of whether they used substances or not were stereotyped as "just another homeless drunk" (CHN9). A lack of support for Indigenous people coming to urban centers via medical travel was also seen as a systemic funding issue related to inequitable care in rural and remote communities.

Inequitable Access to Harm Reduction. CHNs suggested that there was inequitable access to harm reduction care among their Indigenous clients experiencing homelessness, particularly in comparison to White men. Internal mandates and policies emerged as part of the problem of inequitable access to care, which illustrated how some seemingly race neutral policies and mandates related to drugs and alcohol resulted in Indigenous specific harm. Despite the differential harms these policies caused CHNs were hesitant to label them as a form of systemic racism.

Race-based Data. Importantly, none of the CHNs felt that Indigenous persons had equal access to their organization's services compared to White persons. Furthermore, they suggested that their organizations didn't prioritize evaluating whether Indigenous people had equitable

access to their organizations. For example, to their knowledge, race-based data was not consistently collected (or not collected at all) nor analyzed regularly by their organizations to confirm their anecdotal evidence and beliefs about inequitable access among Indigenous clients. Therefore, data were lacking to evaluate access to their various harm reduction programs. CHNs identified possible barriers to collecting race-based data including organizations not facilitating or prioritizing data collection, discomfort among front line staff to ask questions about race, registration forms that were overly lengthy, only available in French and English, and cumbersome for clients with literacy and other challenges resulting in incomplete forms. Some CHNs questioned whether anonymous services (e.g., SCS) could collect those types of identifying information. Other CHNs noted that race-based data were collected for funding purposes (e.g., Health Canada), but all CHNs noted that any data that were actually collected was probably not overly accurate and/or they didn't believe it was collected in a way that would be "pullable from charts" for analysis purposes. Accurate collection and regular analysis of race-based data are requisite to develop specific and measurable action plans to address the problem of inequitable access to harm reduction care. Importantly, action plans to improve access should be developed in collaboration with front-line CHNs, Indigenous people with lived experience of homelessness, and Indigenous organizations/service providers.

Ambivalence and Self-reflection. Questions about equitable access prompted ambivalence and self-reflection. Despite the lack of data to quantify the problem, none of the CHNs felt that Indigenous people had equal/equitable access to their organization's services. Some CHNs were unequivocal that Indigenous people did not have equal access and responded immediately with phrases like "absolutely not, nope" (CHN 4) and "no I don't, I would disagree with that" (CHN 6) and some were also very candid about organizational issues including leadership challenges

and changes in organizational mandates that will be discussed further at the end of this section. Other CHNs were more ambivalent or cautious about how they framed problems of inequitable access to harm reduction care among their Indigenous clients.

> Um, [very long pause] yes, uh, I don't know, yeah, I would again love to say yes. Um, no one would ever be turned away because they're Indigenous here, Indigenous folks are welcome, and that would never be any kind of reason specifically to deny care, refuse care…. Is that sort of what we see and practice? Sort of what I spoke to earlier with that shift of who is accessing care. Not so much… It's hard to get them to physically come in and access care here because of some barriers and because of how they feel and things that have happened in the past here. (CHN8)

Another CHN drew comparisons between harm reduction practices and problems in acute care: "I feel like we do a better job in community than certainly happens in the hospital. But yeah, I'm not sure?" (CHN1). One CHN who noted that their organization had made efforts including bringing in Indigenous healers, offering country food, and developing an anti-racism policy stated, "that's a hard one, because on one hand, I'm really proud of the work we've done… on the other hand… [nurses] have to work harder to make things accessible for Indigenous people than for the general homeless population" (CHN5). Another CHN also suggested that nurses needed to be intentional in their efforts to engage Indigenous communities for access to be equitable but suggested that wasn't happening currently at their center.

> I think if we're going to be honest, I don't know if they like me saying this but a lot of the people that access, for example harm reduction are White young men, but that's not necessarily indicative of people… who use drugs. There is a huge population of women that are addicted, and also… Indigenous persons. So we have to advocate and reform the

> health center to make sure that these people feel safe accessing, because if we're not seeing them there's a reason, you know. Like we're obviously not creating a space in which they feel comfortable. (CHN3)

Some CHNs were introspective about their own role in deterring access to care, but only one specifically refuted that culturally unsafe care was something that was more likely to occur elsewhere and suggested that there was "a lot of stigmatization not only from hospitals and institutions, but also from us" (CHN10). They went on to describe, "I don't think we're able to provide super culturally sensitive care, and or have the training to do it so that's a bit of a struggle" (CHN10). However, most CHNs struggled to identify with examples from their nursing practices with Indigenous clients the ways in which they themselves might be deterring access to care, upholding systemic racism, or perpetuating settler colonialism. Most CHNs simply responded that they were sure that they did, but they were unaware of how.

Internal Mandates. Organizational mandates around different types of substance use were an issue raised by a number of CHNs from the same CHC. I will discuss this issue in more depth because the different perspectives revealed some interesting findings about how CHNs framed the issue of substance use and Indigenous homelessness. It also highlighted challenges with identifying how seemingly race neutral policies have differential impacts on racial groups and can thus be a racist policy. I had to hear all three explanations before I really understood the problem and why all three participants had separately highlighted that the same policy caused inequitable access among their Indigenous clients. The CHNs described how the mandate at their organization changed from their drop-in programs and harm reduction clinic being inclusive of homeless and marginalized clients that used all substances including alcohol, to being exclusively for people that injected or inhaled illicit substances such as crack cocaine, opiates,

and methamphetamines and were at increased risk of Hepatitis C and HIV. This change meant that some Indigenous clients that solely used alcohol and had been accessing the program for a long time, were no longer welcome because they did not meet the new mandate.

These clients had trusting relationships with staff that were built over many years, and the break in relationship deterred access to care among their Indigenous peer networks as well. One CHN described that "the Indigenous folks that had accessed services here that had also come here for decades and were very comfortable here… they didn't feel welcome here anymore" (CHN8). The mandate was recently reversed to be more inclusive, but not all staff were aware of the change and at times continued to turn clients away. Although the mandate had changed, CHNs were still finding it very difficult to rebuild trust and to reengage clients. CHNs described the broken relationships as a result of the change in mandates and the daily outreach work that they were doing to engage Indigenous clients on the street and encourage them to access their program again. Additionally, CHNs noted that broken trust with a few individuals also deterred access to care among a wider network of people within the community of Indigenous people experiencing homelessness. The fallout from the change in mandates highlighted the tenuous nature of trust within relationships and challenges of repairing broken relationships.

The intention of this policy was not to discriminate against Indigenous Peoples. However, racist policies are unlikely to be as blatant as, for example, a sign outside an establishment that says, "White's only" or "No Indigenous Peoples allowed" and racist intent is not requisite for a policy to be discriminatory on the basis of race. Indeed, racist policies are unlikely to mention race at all because this kind of blatant discrimination is against Canada's human rights laws (e.g., the Charter; Canadian Human Rights Act). CHNs struggled to describe differential impacts that a seemingly race neutral internal mandate/drug policy had on their Indigenous clients without

perpetuating stereotypes about Indigenous people and alcohol use disorder. Two of the CHNs were hesitant to make the connection between Indigenous homelessness and alcohol use.

> The mandate… didn't include alcohol use disorder anymore, so that changed a lot of the access for clients and it's tricky to, um I don't know how to speak about that because I feel like it's also lending itself a little bit to a judgment and a bias about attaching Indigenous folks and alcohol use disorder, um, which is I don't know, which is tricky… The clients [that used alcohol] stopped coming… so that included a lot of the Indigenous clients. Not all, obviously, not a blanket statement, but just um an observation. (CHN 8)

Another CHN noted that "when there were clients presenting that didn't do… [illicit drugs and sex work], but had alcohol use disorder, which are not always Indigenous again, but there were a lot of Indigenous clients in that case. They were turned away" (CHN7). Another CHN described the mandate without mentioning alcohol use at all.

> A lot of the Indigenous [people] that I was around downtown all the time and… was having conversations with were not predominantly drug users and so they had other needs and very great needs that weren't being supported by our establishment because of our mandate… unfortunately because they have been not welcome to the clinic and the services because of the other substances that they choose to use it's been a slow trickle in [after the mandates changed back]. (CHN4)

As the participants highlighted, seemingly race neutral policies in the realm of harm reduction may be particularly challenging to label as a racist policy without perpetuating stereotypes.

One of the CHNs described a more blatant example of a racist policy when their organizational leaders refused to smudge with a visiting Indigenous harm reduction organization

and potential care partner. Although, logistics such as smoke detectors may at times be a barrier to smudging indoors, the CHN stated that, “they didn’t even offer to go outside, it was just no” (CHN2). The rationale that was provided by their organization was that they did not have a policy on smudging. The CHN described hearing about the incident after the fact and being incredibly disappointed by their organization. They sent an email to follow up, and described in the email how it was in violation of the TRC Calls to Action, but they reported that they never received a response back, and that there still wasn’t a “smudging policy” in place. Calling out the discrimination inherent in various organizational policies illustrated some tensions between harm reduction and how best to support Indigenous clients, ensure equitable access to care, and to provide cultural supports congruent with harm reduction.

Conceptual Confusion and Practical Applications of Key Concepts

Within my situational analysis and in developing my interview guide, I chose to explore in more detail frameworks that revolved around culture (e.g., cultural safety and cultural competency) and Indigenous rights (e.g., UNDRIP) because of the specific Calls to Action for nursing education by the TRC and also based on my early website reviews that found cultural competency, safety and humility dominated the focus of the CNA and nurse regulators across Canada to address discrimination. Therefore, I explicitly asked CHNs in interviews about their understandings of cultural safety versus cultural competency and I also asked how UNDRIP and human rights influenced their nursing practices. However, harm reduction emerged during the interviews as one of the more important philosophies that informed participants’ understandings of oppressions that their clients faced and provided direction for CHNs anti-oppression work. This finding was not surprising given CHNs’ practice areas. Discourses around the prevalence and problems of intergenerational trauma among Indigenous clients were also predominate in the

interviews, which suggested that TIC may also have been a more familiar framework to CHNs than either UNDRIP and/or cultural safety/competency/humility.

Another key research finding was that many concepts and theoretical frameworks that nurses are called on to apply in codes of ethics and entry level competencies may be difficult to apply in practice. Overlapping concepts and principles may also have led to confusion among CHNs about what exactly they were supposed to do to provide culturally safe care, and how they could engage in anti-racist actions and uphold their commitments to truth and reconciliation. Additionally, it may be overwhelming for nurses to expect that they incorporate a plethora of different theoretical constructs, each with its' own set of principles, into a single individual encounter. A multitude of concepts may be particularly cumbersome to apply simultaneously when encounters are often relatively short and may revolve around the completion of a specific set of tasks such as wound care, giving injections, drawing blood, etc. The barriers described above to a theoretical application of the various stand-alone, yet interconnected, nursing concepts including harm reduction, cultural safety, cultural competency, and TIC supports the need for an overarching framework such as relational ethics.

Perhaps most important for nursing practice is to focus less on abstract concepts and principles and focus more on what kinds of ethical nursing actions will improve health outcomes among Indigenous people experiencing homelessness. Upstream political action and policy work to end Indigenous homelessness are of course pivotal solutions to end suffering and achieve health equity. However, CHNs described that they work in very downstream situations within their harm reduction programs. They expressed the overwhelming need to ameliorate immediate concerns including to address the immense suffering of people experiencing homelessness and their nursing care focused on reducing further harm (e.g., from disability, disease, trauma, and

premature death from overdose and complications related to substance use and inadequate healthcare). Therefore, CHNs spent considerable time working to ensure people did not fall farther through the cracks of a dysfunctional and overstretched system, and they had very little time to address systemic barriers through advocating for changes to the system itself.

In conclusion, this chapter provided a detailed relational ecological overview of the situation of action. Nursing actions occurred at intersections between community health and harm reduction and within the social world of Indigenous homelessness. I used various mapping tools to provide this relational ecological overview, including a social worlds and arenas map (Figure 4.1), which located CHNs social world and intersections with other social worlds and arenas; an ordered situational map (Figure 4.2), which lays out all of the key situational elements that may influence CHNs actions and beliefs; and a positional map (Figure 4.3), which identified key positions taken and not taken within the situation of action. Finally, I described CHNs discursive constructions of Indigenous homelessness and key issues within their social worlds that impacted their nursing practices with Indigenous people experiencing homelessness.

The following three chapters also present qualitative interview findings, but these chapters focus in-depth on a few select elements within the situation and different aspects of the interviews. In the next two chapters, I turn to the TRC Calls to Action, before returning to an analysis of CHNs anti-colonial struggles within themselves and their individual anti-oppressive actions. As part of my situational analysis, I conducted reviews of nursing websites to look for anti-oppression content and examine progress on the TRC calls to action within nursing more generally, which is the focus of the next chapter. I connect these website review findings to the conceptual confusions expressed by CHNs in the interviews and I focus on some theoretical limitations of cultural competency versus cultural safety.

Chapter Five: Myth of Cultural Competency—Analysis of RN Websites

[C]olonial white society assigned itself some crazy Knower's Chair and handed white people the authority to sit in it. They alone get to teach from this chair and decide what is true knowledge, what is false, etc. It is rare that they will give it up so that they can learn from Indigenous people… To assume that you as Canadian (usually white male Canadian) would automatically be my teacher and I your student means you have failed to see me as an emotional and mature being who might find this positioning of yourself as superior to me an insult.

Lee Maracle – Author, academic, and activist from Stó:lō First Nation (2017, p. 76)

The aim of this chapter is to explore anti-oppression approaches to practice in Canadian nursing and progress on implementing the TRC's Calls to Action. The TRC was established in 2008 with the mandate to expose and preserve the true history of the Indian Residential School system in Canada (TRC, 2015). In 2015, the TRC published their final report and 94 Calls to Action for Canadians. TRC (2015) Calls to Action #23 and #24 called for mandatory cultural competency training for nurses and obliged nursing schools to educate students on the enduring impact of colonial violence through education on Indigenous health issues, human rights, treaties, and UNDRIP. The focus of this chapter is on cultural competency, while the following chapter will focus on the importance of UNDRIP, treaties, and human rights to nursing practices. I argue that cultural competency problematically puts nurses into the "knowers chair" described above by Maracle (2017). Over the next two chapters, I argue that relational ethics, community engagement, protection of all human rights, and promotion of Indigenous specific rights as enshrined in Canadian Treaties and UNDRIP are the essence of reconciliation and foundational for anti-oppression work in the academic discipline and professional practice of nursing.

My analysis in the following chapter focuses on extant discursive material and qualitative interviews with CHNs. To begin, I provide background on cultural competency frameworks rooted in Leininger's *Culture Care Diversity and Universality* theory and Ramsden's cultural

safety. Next, I critically examine progress on the TRC Calls to Action and anti-oppression approaches endorsed by Canadian nursing organizations. My analysis explored content on websites of the CNA, Canadian Association of Schools of Nursing (CASN) and provincial nursing regulatory bodies across Canada. I analyzed the degree to which these organizations have enacted anti-oppressive work through practice standards and other practice documents. Based on my review of websites, I identified, and subsequently, critiqued cultural competency and cultural safety as the main approaches to anti-oppressive work in nursing. Through qualitative interviews I explored some of the ways in which CHNs engaged with these cultural approaches in practice, as well as the strengths and limitations of these approaches. Finally, I integrate some of the findings from CHN interviews to critically appraise a few key documents found on nursing websites, including entry level competencies (ELC) documents.

Background

Leininger and Cultural Competency

Madeline Leininger's *Culture Care Diversity and Universality* theory is one of the earliest and most prominent influences on cultural competency (Alligood, 2018). Leininger, a nurse scholar, was also trained as an ethnographer, and her studies with Gadsup peoples in remote Indigenous villages of Papua New Guinea in the 1950's and 1960's influenced her nursing theories and her desire to provide culturally congruent care (Leininger & McFarland, 2006). Cultural competency gained currency within the context of multiculturalism in North America and has been incorporated into most undergraduate nursing curricula (Albougami et al., 2016; Williamson & Harrison, 2010). Although the term cultural competency is specifically named in the TRC (2015) Calls to Action, the efficacy of cultural competency frameworks to address colonialism in healthcare is doubtful. In particular, cultural competency frameworks

rooted in Leininger's work may be problematic (Curtis et al., 2019; Gustafson, 2005; Mulholland, 1995; Pon, 2009). I argue in the following sections that cultural competency has not undergone any radical conceptual shift in the intervening years since Mulholland leveled criticism in 1995, and thus, current approaches to cultural competency may also be problematic. Anti-racism scholars in nursing have repeatedly called for re-orientation away from cultural competency and towards explicitly anti-racist educational interventions that critically deconstruct problems associated with White nurses seemingly benign racial behaviours and beliefs that serve to maintain systems of White supremacy (Bell, 2021, 2023, 2024; Came & Griffith, 2018; Hantke et al., 2022; Hassen et al., 2021; Iheduru-Anderson et al., 2021; Kelly, 2024; Kelly & Chakanyuka, 2021). These scholars' arguments against cultural approaches are rooted in critical theories that contend systemic racism is the root cause of racial health inequities and not nurses' cultural awareness of others or lack thereof.

Theoretical roots of cultural competency and Leininger's theory are bound with traditional strands of ethnography. Ethnography historically perpetuated colonization and racism in the name of scientific knowledge and negative implications of ethnographic research continue today (Green, 2024; Marker, 2009). The principal aim of cultural competency was originally intended to provide culturally congruent care to people of 'other' cultures (Leininger & McFarland, 2006) and not specifically to address racial oppression. Undeniably, being open to learning about Indigenous Peoples' cultures and their healing practices are critical to provide culturally meaningful and individualized nursing care. However, racism, power imbalances, and structural violence all drive population level health disparities, not nurses' lack of knowledge about the many diverse cultural beliefs and practices of Indigenous Peoples (Curtis et al., 2019).

Problematic power relations are evident in Leininger's traditional ethnographic approach. For example, a central tenet of her theory is to compare cultures and look for similarities and differences (i.e., diversities and universalities) between the nurses' cultural care patterns (i.e., White 'western') and those of *other* cultures (Leininger & McFarland, 2006). This encourages complex cultural patterns to be condensed into simplistic systems of representation that can more easily be incorporated into nursing care. The nurse is then supposed to examine the cultural care patterns of other cultures and make determinations based on their own (i.e., White) worldview about what is beneficial, benign, or harmful and determine how nursing care can be more culturally congruent on that basis. For example, the diagram that illustrates Leininger's *Sunrise Enabler Nursing Model* walks nurses through a process that starts with the nurse identifying cultural elements, and based on their perception of other cultures the nurse then determines 'transcultural care decisions and actions' that included three options: 1) cultural care preservation/maintenance, 2) cultural care accommodation/negotiation, or 3) cultural care repatterning/restructuring, which supposedly lead to the outcome of 'culturally congruent care' (Leininger & McFarland, 2006). The notion that nurses should determine which cultural practices should be preserved and which should be repatterned is highly problematic.

Therefore, risks of enacting Leininger's theory and related cultural competency frameworks are that the nurse may be seen as expert in determining which cultural behaviours are healthy or unhealthy, and incorrectly attribute behaviours and illnesses to cultural practices and beliefs as opposed to structural factors such as systemic racism and poverty (Curtis et al., 2019; Gustafson, 2005; Mulholland, 1995; Pon, 2009). Cultural competency problematically rests on recognition of difference and may perpetuate othering. Additionally, the White nurse's culture is still the standard by which other cultures are judged and this positions the nurse as

expert and minimizes the central problem of racist power differentials (Curtis et al., 2019; Gustafson, 2005; Mulholland, 1995; Pon, 2009). Given this theoretical baggage, it is reasonable to suggest that cultural competency be abandoned in favor of explicitly anti-racist and anti-oppressive approaches to nursing care.

Cultural Safety, Cultural Humility, and Relational Ethics

Cultural safety and cultural humility shift the balance of power towards positioning the nurse as learner and the client as expert knower (Ramsden, 2002; Tervalon & Murray-Garcia, 1998), but nurses have melded cultural safety, cultural humility, and cultural competency together. Interestingly, both cultural humility (Tervalon & Murray-Garcia, 1998) and cultural safety (first developed by Ramsden in the late 1980's) emerged as a rejection of the concept of cultural competency (Koptie, 2009). As Māori nurse Irapeti Ramsden argued, White nurses needed to learn about the history of colonization and, in 1991, cultural safety became a nursing curriculum requirement in Aotearoa, also known as New Zealand (Koptie, 2009). Ramsden criticized cultural competency for essentializing cultural differences, perpetuating stereotypes and othering, failing to consider power within relationships, and not requiring nurses to reflect on their own attitudes and behaviours (Ramsden, 2002). These criticisms were repeated by many nursing scholars and Indigenous organizations in Canada. Collectively, this literature encouraged a move away from cultural competency and towards an approach that combined cultural safety, cultural humility, relational ethics (Bourque Bearskin, 2011; Brascoupé & Waters, 2009; Browne & Varcoe, 2006; Carey, 2015; Dion Stout, 2012; Downey, 2020; Fraser, 2022a, 2022b; Kelly & Chakanyuka, 2021; Koptie, 2009), and more recently, Trauma informed care (TIC) (British Columbia College of Nurses and Midwives, 2022; FNHA, 2020), or trauma and *violence* informed care (TVIC) (Browne et al., 2016).

Woods (2010) suggested that relational ethics underpins the concept of cultural safety, as originally envisioned by Ramsden. In her doctoral thesis, Ramsden (2002) described cultural safety, or *kawa whakaruruhau*, as grounded in both Māori worldviews and critical social and feminist perspectives such as Paulo Freire, bell hooks, and Patti Lather. Ramsden focused on power differentials within the nurse-person relationship as central to cultural safety. Similar to the TRC (2015) Calls to Action in health, Ramsden (2002) also emphasized the importance of understanding and honoring treaties to orient healthcare towards Indigenous health equity. She considered the Treaty of Waitangi in Aotearoa an essential part of a framework for ethical relations between Māori and Pākehā (non-Māori or settler) nurses and critical for advancing health equity. However, Ramsden argued that with the implementation of cultural safety by the Nursing Council of New Zealand, attention to the Treaty of Waitangi was diminished and cultural safety was depoliticized (Ramsden, 2002).

Additionally, Ramsden (2002) expressed concerns that the critical Indigenous and anti-racist foundations of cultural safety were being eroded, as the concept of cultural safety was being merged with the concept of cultural competency and Leininger's transcultural nursing theories. She described some common and incorrect assumptions about cultural safety found in ubiquitous nursing textbooks such as Potter and Perry's *Fundamentals of Nursing*: "firstly, that culture and ethnicity are synonymous. Secondly, that Cultural Safety is about something confusingly called biculturalism and students learning Māori language and customs, and thirdly, that nurses can predict culturally-based behaviour, and have the right to control the practice environment accordingly" (Ramsden, 2002, p. 106). Since 2002 the concept of cultural safety has spread beyond Aotearoa and is now integrated into Canadian nursing.

I argue that Ramsden's criticism also holds true in the Canadian and Ontario contexts as well. For example, the Registered Nurses Association of Ontario (RNAO) *Best Practice Guideline: Embracing Cultural Diversity in Health Care: Developing Cultural Competence*, defined cultural safety as inclusive of "cultural awareness, cultural sensitivity and cultural competence and involves the recognition of unequal power relations to address inequities in health care" (2007, p. 70). The RNAO document, which unfortunately hasn't been updated since 2007, concentrated on DEI in nursing workplaces and not the provision of culturally competent care. Regardless of the document's focus, it framed diversity as the "challenge" to be addressed rather than racism as the problem. It also paid scant attention to systemic racism and focused on bias rather than how socially constructed systems are designed to privilege some groups of people (i.e., White settlers) at the expense of others. In other words, this document lacked attention to systemic racism. As cultural safety frameworks have proliferated in other contexts, they have sometimes applied an intersectional lens to address multiple other forms of oppression and discrimination (e.g., to ensure healthcare is culturally safe for people with (dis)abilities, or diverse gender identities), which overall is a positive approach. However, a consequence of this broader focus is that in many ways, cultural safety is no longer an Indigenous specific concept as Ramsden intended.

Measuring Effectiveness of Cultural Competency/Safety

There are a number of systematic reviews that have attempted to evaluate the effectiveness of cultural competency interventions (Clifford et al., 2015; Gozu et al., 2007; Kumas-Tan et al., 2007; Loftin et al., 2013; Osmancevic et al., 2021; Yadollahi et al., 2020). Attempts to measure cultural competency are not a recent phenomenon in nursing; for example, Gozu et al. (2007) systematically reviewed interventions to measure cultural competency

inclusive of studies from 1980-2003 and found that measurement tools relied on measures of self-efficacy (e.g., self-reported confidence/awareness/skills) that were evaluated pre/post educational intervention, and that tools were typically not assessed for validity and reliability prior to their use. Gozu et al. (2007) concluded that "measuring and understanding the effect of cultural competence training on learner attitudes, knowledge, skills, and behavior are both fundamental" to improved care in a multicultural context and that despite considerable limitations to existing measures that "they do provide a starting point on which to build the development of future measurements of cultural competence" (p. 188).

Kumas-Tan et al. (2007) also systematically reviewed 54 instruments to measure cultural competency interventions and identified a number of problems inherent to measuring cultural competency. They concluded that "existing measures embed highly problematic assumptions about what constitutes cultural competence. They ignore the power relations of social inequality and assume that individual knowledge and self-confidence are sufficient for change" (p. 548). These divergent systematic review conclusions, both of which were reached in the same year (2007), offered conflicting and competing views about the efficacy of cultural competency that continue today (Bell, 2021, 2023, 2024; Campinha-Bacote, 2019; Galan-Lominchar et al., 2024; Hantke et al., 2022; Hassen et al., 2021; Iheduru-Anderson et al., 2021).

Ramsden (2002) suggested that there was a need for clear definitions of cultural safety to translate this theoretical concept into action. Ramsden also proposed a key area for research was how to assess cultural safety in clinical practice. Cultural safety frameworks suggest that the person receiving care ultimately determines whether care is culturally safe and these shifts in power are important (Curtis et al., 2019; Dekker, 2016; FNHA, n.d.; Ramsden, 2002). Therefore, tools that measure nurses' self-reported cultural awareness and confidence are irreconcilable

with cultural safety because the power to determine culturally safe care lies with the person receiving care. However, evaluating cultural safety in a patient/client centered way may not offer practical guidance for nurses to reflect on their own clinical practices without soliciting feedback from patients, which may be burdensome to people in need of care. For example, marginalized people may feel unsafe to answer nurses' questions about how the nurse's own behaviours impacted them. Anderson et al. (2003) attempted to understand whether nurses' behaviours could be recognized as culturally safe or unsafe in clinical situations. They suggested that their research "sheds light on the conundrums of making the link between abstract concepts, such as cultural safety, and everyday practical reasoning in clinical settings" (Anderson et al., 2003, p. 197). Research must explore how nurses understand cultural safety and other anti-oppressive approaches and their perspectives on implementing these approaches in clinical practice; however, quantifying cultural safety in clinical practice may be a logistical impossibility.

Cultural competency interventions continue to be developed and rooted in problematic assumptions about culture and self-reported competence, albeit interventions have become more sophisticated. For example, Galan-Lominchar et al. (2024) incorporated a virtual international exchange program and clinical simulation learning into their multi-country, longitudinal, quasi experimental cultural competency study (intervention group n=70 and control group n=288). The study appeared to be resource intense and rigorous, but it still focused on self-reported measures in the form of Likert-type scales of "cultural intelligence" that was defined as the "capability of an individual to function effectively in situations characterised by cultural diversity" (Galan-Lominchar et al., 2024, p. 2). None of the 4 components of cultural intelligence that they defined focused on anti-racism, implicit bias, or understanding problems of whiteness, privilege, and oppression. Cultural intelligence instead focused on awareness and norms of other cultures that

were foreign to the participants. Additionally, power to determine competence problematically still rested with the nurse providing the care and not the person receiving the care. Many nurse scholars argued, and I agree, that cultural competency is not inherently an anti-racist approach (Curtis et al., 2019; Gustafson, 2005; Mulholland, 1995; Pon, 2009), additionally, measuring cultural competency using self-reported measurement tools further imbeds problematic relational power imbalances between nurses and the people receiving care. I now turn to my analysis of nursing websites in Canada and CHNs understandings of cultural safety/competency, their self-identified training and educational needs, and their reflexive practices.

Methods and Data Sources

Part 1: Website and Document Reviews

Websites of the CNA, CASN, and provincial and territorial RN regulatory bodies (referred to as colleges) were the focus of my analysis in this chapter. These websites, and the practice documents found on them, are relevant to, and intended to shape, Canadian nursing practice. They give an indication of approaches to anti-oppressive work endorsed by colleges, and thus, ideally practiced by RNs, and suggested whether academic work is being translated into action in nursing practice. All RNs, in Canada, must be licensed by their provincial college, and they must visit their college website at least once a year to renew their registration. Colleges have obligations to protect the public, develop and enforce practice standards, and ensure ongoing competencies of practicing nurses through learning plans and self-assessments related to practice standards. Although nursing is a provincially regulated profession, the CNA provides leadership and offers a consistent vision for nursing colleges and associations. The CNA develops practice documents such as ethical codes and advocates for changes at the provincial level. Previously the CNA administered the Canadian Registered Nurses Exam (CRNE), which

was replaced by the National Council Licensure Examination (NCLEX) administered by a private company in 2011. CASN was chosen because they are responsible for nursing schools' accreditation and offer curricular direction. One of the review limitations is that websites were solely reviewed in English, and as a unilingual anglophone, I was unable to review the website of the Ordre des Infirmières et Infirmiers du Québec (Québec regulatory college) and the French versions of the CNA and CASN websites.

In April of 2022, I reviewed all websites to look for anti-oppression content, practice documents, links to external resources, and in the case of colleges, to what extent their membership were held accountable to the TRC Calls to Action, including learning about colonization and approaches to address health disparities and anti-Indigenous discrimination. During initial reviews, I explored the websites looking for commonalities in key concepts related to anti-oppression. I navigated websites from their homepages. I also used the search function to look for additional documents, internal webpages, and links to external websites related to racism and oppression using key words including 'racism' and 'cultural' or 'culture'. Based on this initial review I developed a critical appraisal guide. Using this guide, I reviewed the websites again. I compared each of the provincial colleges' websites and documented my findings of anti-oppression content and evidence of commitments to TRC Calls to Action, such as educational resources and measures to ensure accountability of their membership. During my initial review it was obvious that some colleges were above average while others had non-existent evidence of their commitment to anti-oppression and the TRC Calls to Action. The remaining colleges were somewhat average and fit on a continuum between the two extremes of the spectrum. I attempted to discern and document which colleges were average, above average, or below average in their progress towards truth and reconciliation. However, I did not apply any quantitative scoring

systems. These reviews were repeated again in April of 2023 to look for new content, evidence of progress on the TRC Calls to Action and/or any changes to practice documents.

The final reviews of websites were conducted in April of 2024. Prior to the final review, I revised my critical appraisal guide to include a more rigorous qualitative evaluation process and incorporated an equity competencies framework based on a framework by Russell and Flynt Wallington (2022). Russell and Flynt Wallington (2022) modified the *Common Health Action Equity Competencies* to assess perspective transformation among US nursing organizations. Their goal was to explore whether organizations had oriented their perspectives towards equity and a structural/systemic approach. They assessed perspective transformation based on organizations' anti-racism statements in the wake of George Floyd's death. They articulated 6 competencies: (ACK) acknowledging privilege and oppression within healthcare, (ART) articulating message through common language, (COM) committing to racial justice and learning, (DEV) developing or proposing policy, (FRA) framing death of George Floyd through an equity lens, and (KNO) knowing the historical context. I modified Russell and Flynt Wallington's (2022) competency framework to be more inclusive of anti-colonial language and to focus on anti-Indigenous racism. I also included three additional competencies including: evidence of (ACT) actioning, and (EVA) evaluating proposed policy/practice changes, as well as, whether or not there was evidence of (INV) involving Indigenous Peoples in the processes. See Table 5.1 below for definitions of equity competencies.

One of the limitations of the websites reviews are that the total equity competency (TEC) framework was not applied to the initial reviews, and therefore it is difficult to measure progress. Measuring progress on the TRC Calls to Action must be an ongoing process and my website reviews were an exploratory step that offers important directions for future research. Another

limitation was the lack of a second reviewer to assess for inter-rater reliability. Therefore, for a number of reasons, I chose to qualitatively assess the websites and did not assign a quantitative score to either the TEC checklist or the critical appraisal guide. Arguably, some elements on both the TEC and critical appraisal guide should be weighted differently than others to determine a quantitative score. Moreover, quantitative scoring criteria should be developed in collaboration with Indigenous expertise and an advisory panel of both nurses and community stakeholders.

Table 5.1

Total Equity Competencies Checklist

Equity Competency	Definition of Equity Competency
Acknowledging (ACK) privilege and oppression in healthcare.	The college or document acknowledges the effect of privilege and oppression within the healthcare system (i.e., discusses health disparities in relation to racism and colonization).
Articulating (ART) message through common language.	The college or document uses language, to include words, phrases and concepts, that are commonly accepted within anti-racist and/or anticolonial theory (e.g., naming racism, discrimination, white supremacy, privilege, oppression, colonization, settler colonialism).
Committing (COM) to racial justice, TRC learning.	The college or document expresses a commitment to expanding knowledge, skills, and understanding of racial injustice and colonization through inquiry and continuous learning of their membership or makes a broad commitment to engage in anti-racist or anti-colonial action.
Framing (FRA) of health disparities through an anti-colonial or anti-racist lens.	The college or document frames Indigenous health disparities through the lens of anti-colonialism to evaluate and assess the unfair benefits and burdens within a society or population (i.e., inequities).
Knowing (KNO) the historical context.	The college or document refers to the history of colonization and evolving policy environment that created past and current legal and social systems that privilege/oppress certain populations.
Involving (INV) and collaborating with Indigenous Peoples.	The college or document describes a process for meaningfully involving Indigenous Peoples (e.g., Elders, knowledge keepers, scholars, organizations) to develop content, policies or practice changes. Evidence of involvement also includes reporting that board members, committee members or leadership identify as Indigenous.
Developing (DEV) or proposing policy or practice changes.	The college or document proposes or outlines policy or practice changes with a focus on anti-oppression and health equity (e.g.,

	mandatory training of their membership, accountability measures or orienting complaints process towards anti-racism).
Actioning (ACT) and implementing changes.	The college or document reports that they have implemented their proposed policy or practice changes.
Evaluating (EVA), reporting and transparency.	The college or document evaluates practices and policies through an equity lens (e.g., hires Indigenous consultants to assess policies and practices) and reports the findings publicly on their website.

Part 2: Qualitative Interviews

The second portion of my analysis of cultural competency consisted of qualitative interview data collected between October 2023 and January 2024 with CHNs working in harm reduction in an urban center in ON. These interviews were in-depth and focused on several different areas of CHNs anti-oppression work and intersections with Indigenous homelessness. The findings presented in this chapter related to a number of interview questions that specifically focused on cultural safety and cultural competency. The methods of data collection and analysis of this portion of the qualitative interviews followed the same SA approach detailed in chapter three. Questions related to cultural safety/competency were developed, in part, based on initial website reviews. I was able to explore how CHNs' understandings of approaches to anti-oppressive practices converged or diverged with ELC documents and the CNO's and CNA's theoretical perspectives and approaches to practice. Notably, all the participants had taken some form of additional cultural competency/safety training. I suggest that, as compared to my sample, it would not be the norm among nurses in Ontario for all of them to have taken additional training. Therefore, this may reflect a sampling bias.

Findings

Part 1: Findings From Websites and Practice Documents

Two main approaches to anti-oppressive work endorsed by RN organizations included social justice, and cultural competency/safety. The current CNA (2017) code of ethics called for nurses to engage in social justice and virtually all provincial colleges, except Ontario, refer their membership to this document (codes of ethics/conduct will be explored in the next chapter). Despite the prominence of social justice in the CNA code, none of the provincial colleges had practice documents for social justice. Instead, they focused on cultural frameworks as their approach to address discrimination. Cultural competency, safety, and humility are typically distinct theories in the nursing literature, but some provincial RN documents, the CNA (2018), and joint Aboriginal Nurses Association of Canada[5] (ANAC), CNA and CASN (2009a,b) documents combined them together as one approach. I delineate this further in final sections of this chapter and attempt to deconstruct the theoretical underpinning of the cultural competency approaches described by CNA, ANAC, and CASN. See Table 5.2 for a complete list of websites that I reviewed and summary of findings. Table 5.3 contains results of the TEC qualitative appraisal. Table 5.4 identifies key concepts that I searched for in the ELC and practice standards and whether these concepts were referenced in the reviewed documents or not.

Initial 2022 Review. The initial website review in April of 2022 found the following: The CNA and many provincial nursing colleges and associations across Canada had pledged their support on their websites to uphold the TRC recommendations (e.g., British Columbia College of Nurses and Midwives, 2022; CNA, 2021b). Furthermore, the CNA published anti-racism

[5] The ANAC is now the Canadian Indigenous Nurses Association (CINA); however, to avoid confusion I will reference ANAC according to the authorship reported on the actual published document.

position statements and their 2017 Code of Ethics called on nurses to engage in social justice and advocacy (CNA, 2017; 2021a, 2021b). The CNA also pledged their support on their website to uphold Joyce's Principle (2020). I did not include the CNA and CASN websites in the qualitative appraisal matrix, because they serve different functions from the regulatory colleges, and as such documents found on their websites were considerably different from those on regulatory websites and were not comparable.

CNA and CASN both displayed detailed anti-racism declarations and demonstrated this commitment with in-depth documents on their websites along with external links to resources. Among the provincial colleges, British Columbia (BC) was the only college to include a separate cultural safety practice standard and self-assessment questions (new for 2021) as part of their license renewal process. Yukon (YK) prominently displayed a commitment to cultural safety and humility on their homepage, but it is a small organization with an overall sparse website, few resources, and represents a small nursing workforce. Saskatchewan (SK), Manitoba (MB), New Brunswick (NB), Nova Scotia (NS), and the joint college for the Northwest Territories (NT) and Nunavut (NU) included toolkits, practice expectation spotlights, or case studies on cultural safety/competency. They also included some readily accessible external links on their websites. Alberta (AB), Ontario (ON), Prince Edward Island (PE), and Newfoundland (NF) colleges had disappointing websites. They had no separate practice documents on anti-oppression and/or anti-racism and few external links to resources, which were not displayed prominently or readily accessible on their websites. ON had a webpage with one paragraph on 'cultural sensitivity' with links to government websites, such as the Ontario Human Rights Commission, but no links to Indigenous organizations. AB's homepage had a land acknowledgement that felt rather empty in the absence of other anti-racist content and actions to hold their membership accountable to the

recommendations of the TRC. The registered nurses' associations of the YK, and the NT/NU serve as both the regulatory colleges and provincial nursing associations. Given the small size of these two organizations, their respective websites did not have much content in general, and this was taken into consideration when evaluating them. Similarly, the Maritimes provinces also have smaller nursing membership and regulatory colleges compared to some of the larger provinces.

Most provincial colleges had RN practice standards documents on their websites in addition to their ELC documents, while YK and MB had only one document. Generally, the practice standards related to ethical conduct while the ELCs related to nursing knowledge and skills expected of nurses entering the profession. Although, most of the ELC documents were based on the Canadian Council of Registered Nurse Regulators (CCRNR; 2018), there were subtle differences in their inclusion/emphasis of various key concepts. There were considerably more variations between provincial colleges in their practice standards documents. The differences related to inclusion of key-concepts are captured in table 5.3 below. The TRC was mentioned in most provincial ELC documents based on the CCRNR (2018) *Entry-Level Competencies for the Practice of Registered Nurses.* Most provincial ELC documents found on the nursing college websites, with minor variations, defined cultural humility and "culturally safe environment" in the glossary and briefly mentioned these terms in the body of the document.

Progress Update 2023. In April 2023, websites were reviewed again to check for updated content. CASN highlighted that anti-racism and attention to the TRC Calls to Action were a gap in the previous national framework and attempted to redress this in their most recent framework. The CNA had no significant updates to their website in the areas of cultural safety or antiracism. There was considerable variability between provincial regulatory colleges in terms of

progress with some websites displaying no evidence of action at all and others continuing to set goals related to TRC Calls to Action and track their progress in transparent ways.

YK had some improved content and accountability measures. For example, their website had new links to BC College of Registered Nurses and Midwives (BCCRNM) resources, and they reported they have a zero-tolerance policy for Indigenous-specific racisms in nursing practice. Additionally in May of 2022 YK adopted a cultural safety practice standard based on BCCRNM's that discussed racism and colonization. BC had a few new and exemplary documents including the *1 Year Progress Update to Constructive Disruption* and the *BCCRNM's Commitment to Action: 2023–24 Redressing Harm to Indigenous Peoples in the Health-care System.* BCCRNM also released their *Final report: Looking Back to Look Forward (Review of Complaints Process)*, this research is essential to the RN colleges' mandates to the protection of the public from harm through dealing with complaints of misconduct including anti-Indigenous racism and nursing violence against Indigenous persons in healthcare settings.

AB had some minimal updates to their DEI page with a section titled "Indigenous advisory work." This webpage, which consisted of acknowledging various days such as National Indigenous Peoples Day, did not meaningfully describe the college's actual advisory work, for example, the webpage did not describe anti-racist actions, goals and timelines for policy development and practice changes, nor did it describe whether Indigenous Peoples were involved in their DEI work. I would consider the acknowledgments on AB's DEI webpage to be largely symbolic that in the absence of evidence of actual action seemed performative and tokenistic. SK had a call for participants to help record an apology video in May 2023 as part of their TRC commitment, which also risks becoming performative if not done within an authentic partnership with Indigenous Peoples. MB reported changes implemented in Jan 2023 that included updated

practice expectations with a greater emphasis on cultural safety and anti-racism practices. I did not identify changes to any other websites related to anti-oppression content.

Final 2024 Analysis. Final reviews of websites were conducted in April of 2024. BC continued to lead the way in terms of providing evidence on their website of meeting the total equity competencies and the TRC Calls to Action. New documents included: *Guidelines for Working with Indigenous Elders and Knowledge Keepers*; *Honoraria and Expense Reimbursement for Indigenous Services*; and a *Progress Update on 2023-24 Redressing Harm Plan*. BC demonstrated a commitment to implementing the TRC Calls to Action and provided transparent evidence of their action plan with goals and timelines and meaningful progress updates each year. Additionally, the first two documents suggested that they are involving Indigenous Peoples in their work and compensating them accordingly.

AB released a 5-page document titled *Practice Advice: Culturally Safe and Inclusive Practice*. This document was difficult to locate even with the search function on their website and the homepage contained no obvious links to the document. This document was comparable to practice expectations/spotlights that other colleges already had posted on their websites during my previous searches. Additionally, the term *advice* implies that it is a suggestion rather than obligation to practice cultural safety. SK released their video that they alluded to in 2023. This video was essentially an apology and declaration to uphold the TRC Calls to Action. It was an exemplary video that was clearly produced with involvement of Indigenous Peoples. SK's video was posted on a webpage dedicated to reconciliation with links prominently displayed on their website's homepage that directed attention to their work. Unfortunately, this video was not accompanied by written policy documents that clearly articulated nurses' responsibilities to the

commitments that they make in the video, nor did SK provide any concrete plan of action to uphold the commitments they made in their video.

MB reported on their website that they had introduced new jurisprudence modules. Effective with the 2024 registration year, the jurisprudence module, *Health Equity and Cultural Humility* became mandatory; additionally, to take effect in 2025, the jurisprudence module, *Treaty Essential Learnings: The Treaty Experience in Manitoba* will be mandatory (available online for their membership in Spring 2024). Unfortunately, these documents were not available publicly on their website, and members must log in to see the jurisprudence content. MB's website also provided scant details about the development or nature of the content. Improved measures to hold their membership accountable to TRC learning is an important step for all colleges, and MB clearly went beyond declarations and commitments towards actual action that strives to meet the TRC Calls to Action in health. However, given that colleges have an obligation to protect the public from nurses' anti-Indigenous racism, it would be reasonable to expect that more details of MB's modules were made publicly available on their website and open to critique by others, including Indigenous people seeking nursing care.

ON released a new code of conduct that included a cultural safety principle and short animated educational videos to explain the new principle. Inclusion of cultural safety into the code of conduct is an important accountability measure. Notably, this principle is relevant to all forms of oppression (e.g., gender identity and sexual orientation and various forms of racisms and religious discrimination) and was supposedly based on BC's practice standards. However, compared to BC, discussions/explanations about colonization are absent in both the videos and the actual code. This is unfortunate since BC's materials make connections between Indigenous health inequities and colonialism explicit. Thus, BC's versions of cultural safety documents are

more consistent with the original spirit and intent of Ramsden's cultural safety to specifically address anti-Indigenous racism. The animated videos ON produced to explain cultural safety are also in sharp contrast to the one recently produced by SK, as described in previous paragraphs. Despite ON's release of their new code of conduct, they made no commitments anywhere on their website to explicitly address anti-Indigenous racism, nor did they make commitments to action on the TRC Calls to Action, and they do not mention Joyce's Principle. Additionally, links to the cultural safety principle in the code of conduct is simply referred to as "Principle 2," which made these cultural safety resources problematically hard to locate. I found these new cultural safety resources only because I utilized the colleges' key-word website search functions.

NT/NU, PE, NF, NB provided no evidence of progress on the TRC Calls to Action since the initial reviews in 2022 and no updated anti-oppression content. NB's links to cultural safety resources were previously displayed on their homepage, but these links were no longer visible suggesting that their commitment to cultural safety had regressed rather than progressed. Despite NS's earlier strong declarations against racism and commitment to anti-racist action, their website provided little evidence of that commitment with actual action and updated anti-oppression content. In the last 2 years, NS's website also provided no evidence of improved accountability measures. They noted that they would be implementing a survey about culturally responsive care and hopefully this is the first step in a plan of action to implement changes. Table 5.2 below provides a summary of my findings from 2022-2024.

Table 5.2

Summary of Nursing Websites Review: Progress and Content

Organization	Summary Review of Nursing Websites
Canadian Nurses Association **https://www.cna-aiic.ca/home**	*April 2022* Key practice documents included: • Code of Ethics for registered nurses included social justice. • Nursing Declaration Against Anti-Black Racism in Nursing and Health Care. • CNA's Key Messages on Anti-Black Racism in Nursing and Health. • Nursing Declaration Against Anti-Indigenous Racism in Nursing and Health Care. • Promoting Cultural Competence in Nursing. • Aboriginal Health Nursing and Aboriginal Health: Charting Policy Direction for Nursing in Canada. • Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing.
	April 2023 • No updated content
	April 2024 • No updated content on website. • As per email communications CNA had equity-oriented focus groups to update Code of Ethics and called for committee members for anti-racism and Indigenous relations.
Canadian Association of Schools of Nursing **https://www.casn.ca**	*April 2022* Key practice documents included: • Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing (2009). • Discussion Paper: Cultural Competence and Cultural Safety in First Nations, Inuit and Métis Nursing Education (2009). • CASN Anti-Racism Statement. • Canadian Association of Schools of Nursing Statement of Commitment against Anti-Indigenous Racism. • Educating Nurses to Address Socio-Cultural, Historical, and Contextual Determinants of Health among Aboriginal Peoples (2013).

	• Framework of Strategies for Nursing Education to Respond to the Calls to Action of Canada's Truth and Reconciliation Commission (2020)
	April 2023 • New CASN national framework: highlighted anti-racism and TRC calls to action were a gap in previous framework and attempts to redress this in new framework. • Addressing the Truth and Reconciliation Calls to Action in Nursing Education: Workshop Series
	April 2024 • Notification that they are updating Cultural Competency/Safety Framework • Apology to Indigenous Peoples (Dec 2023) • Indigenous Nursing Student and Faculty Survey Report, 2021-2022 • Promoting Anti-Racism in Nursing (2023)
Yukon (YT) Registered Nurses Association (College) **https://www.yrna.ca**	*April 2022* • Our Commitment to Cultural Safety and Humility (this title is the first thing you see on the homepage with a link to "In Plain Sight" Report on Racism in BC. • Land acknowledgment on homepage. • No separate practice standard, position statements or in-depth discussion papers, but overall, it was a very small and underdeveloped website.
	April 2023 • Same commitment to cultural safety and humility as homepage. May 2022 adopted a cultural safety practice standard based on BC's that discusses racism and colonization. Noted that they have a zero-tolerance policy for indigenous-specific racism in practice. Links to BC's resources. Improved content and accountability measures.
	April 2024 • No updated content.
College and Association of Northwest Territories (NT) and Nunavut (NU) **https://cann.ca** **(Formerly https://rnantnu.ca)**	*April 2022* • Links to CNA resources and Code of Ethics. • RNANT/NU Cultural Safety Position Statement.
	April 2023 • No updated content.
	April 2024 • No updated content.

British Columbia (BC) College of Nurses and Midwives **https://www.bccnm.ca**	*April 2022* • Practice standards for all BCCNM registrants: Indigenous cultural safety, cultural humility, and anti-racism practice standard that is separate from main practice standards document. • Two new self-assessment questions related to cultural safety and humility: I reflect on how my beliefs, values, biases, conduct and position of power as a healthcare provider may impact Indigenous clients' health care experiences. I take action to identify, address, prevent and eliminate Indigenous-specific racism. • Multiple links to external resources and training. • An apology to Indigenous Peoples and pledge to be anti-racist (internal web page). • Midwives collecting data on who has completed San'yas Anti-racism Indigenous Cultural Safety Training Program. • Report: Constructive disruption to Indigenous-specific racism amongst B.C. Nurses and Midwives. • Remembering Keegan: a BC First Nations Case Study Reflection
	April 2023 • 1 Year Progress Update to Constructive Disruption. • BCCNM's Commitment to Action: 2023–24 Redressing Harm to Indigenous Peoples in the Healthcare System. • Final report: Looking Back to Look Forward. (Review of Complaints Process)
	April 2024 • Guidelines for Working with Indigenous Elders and Knowledge Keepers • Honoraria and Expense Reimbursement for Indigenous Services • Progress Update on 2023-24 Redressing Harm Plan
College of Registered Nurses of Alberta (AB) **https://www.nurses.ab.ca**	*April 2022* • No separate practice standards, practice directives, or position statements on cultural safety/competency or racism. No links to outside resources. • Home page gives a land acknowledgement. • Internal webpage on diversity, equity and inclusion (DEI) included a few news briefs.
	April 2023 • Minimal updates to DEI page with a page for their Indigenous advisory work consisting of a few news bulletins acknowledging various days such as National Indigenous Peoples day etc.

	April 2024 • Practice Advice: Culturally Safe and Inclusive Practice (June 2023) (5 pages and very difficult to locate) • No changes other than additional news bulletins released on their DEI page.
College of Registered Nurses of Saskatchewan (SK) **https://www.crns.ca**	*April 2022* • Manager toolkit: Cultural Competence. • Manager toolkit: Truth and Reconciliation. • Search function on website found no mention of word racism. • No land acknowledgment.
	April 2023 • Call for participants to help record an apology video in May 2023 as part of TRC commitment.
	April 2024 • Web Page on TRC with Video that acknowledges harms and commitments to TRC and anti-racism. No concrete action plan
College of Registered Nurses of Manitoba (MB) **https://www.crnm.mb.ca**	*April 2022* • Practice Expectation Spotlight: Confronting Racism. • Practice Expectation Spotlight: Self-Reflection in Action. • Practice Expectation Spotlight: Cultural Safety. • No land acknowledgment.
	April 2023 • Webpage with commitment to TRC with Land Acknowledgment (Not on home page) • Dec 2022 Updated practice expectations with new section on cultural safety and anti-racism practice. No other updated content.
	April 2024 • 2024 Mandatory jurisprudence module, *Health Equity and Cultural Humility.* • 2025 Mandatory jurisprudence module, Treaty Essential Learnings: The Treaty Experience in Manitoba (available Spring 2024) (Not publicly available for review. Members must log in to see the content.)
College of Nurses of Ontario (ON) **https://www.cno.org**	*April 2022* • Page titled Culturally Sensitive Care with few links to external sites. • No separate practice standards or position statements. • No Land Acknowledgment.

	April 2023 • No updated content.
	April 2024 • Updated Code of Conduct June 2023 (principle 2 of 6 is "Nurses provide inclusive and culturally safe care by practicing cultural humility") • 3 (2-3 minute) videos locate under Principle 2 learning modules. Difficult to locate because it is simply referred to as Code of Conduct Principle 2 learning resources and does not mention cultural safety in the title. (Replaced the page on culturally sensitive care). (No mention of colonization or TRC, not specific to anti-Indigenous racism). • Updated links to external resources including BCCNM
Ordre des infirmières et infirmiers du Québec, (QC) **https://www.oiiq.org**	• Unable to review; website in French only.
Nurses Association (College) of New Brunswick (NB) **http://nanb.nb.ca**	*April 2022* • Links to cultural safety resources on their homepage. • Page titled: Supporting Culturally Safe Nursing Care. • Standard 3: Client-Centered Practice included Case study: Providing Culturally Safe Care • Search for racism found no results. • No land acknowledgment.
	April 2023 • No updated content
	April 2024 • No updated content. • Links to resources no longer visible on home page.
College of Registered Nurses Newfoundland Labrador (NF) **https://crnnl.ca**	*April 2022* • No separate practice standards, practice directives, or position statements on cultural safety/competency or racism. No links to outside resources. • No land acknowledgment.
	April 2023 • No updated content.
	April 2024

	• No updated content.
College of Registered Nurses of Prince Edward Island (PE) **https://crnpei.ca**	*April 2022* • No separate practice standards, practice directives, or position statements on cultural safety/competency or racism. No links to outside resources. • No land acknowledgment.
	April 2023 • No updated content.
	April 2024 • No updated content.
Nova Scotia (NS) College of Nursing **https://www.nscn.ca**	*April 2022* • Statement from NSCN Regarding Anti-Black and Indigenous Racism in Nova Scotia. • Cultural Safety and Humility Practice Support Tool. • No Land Acknowledgment.
	April 2023 • No updated content.
	April 2024 • Land Acknowledgement (not on home page, difficult to locate could have been there during previous reviews) • Survey to Guide Next Steps In Building Culturally Responsive Care for Nova Scotians

Table 5.3
Provincial Nursing Regulatory Colleges Total Equity Competency[6] Analysis

Provincial College	ACK	ART	COM	KNO	FRA	INV	DEV	ACT	EVA	Notes
BC	✓	✓	✓	✓	✓	✓	✓	✓	✓	Evidence of action in all areas
AB	✓									A few news briefs on their DEI page are only thing available
SK	✓	✓	✓	✓	✓	✓				Video is the main action to date
MB	✓	✓	✓	✓	✓		✓	✓		Jurisprudence modules but no indication what they contain or how they were developed
ON	✓						✓			New cultural safety principle (not Indigenous specific)
NB										No evidence of orienting towards equity
NS	✓		✓							Declaration against racism in 2020 but no action since
PEI										No evidence of orienting towards equity
NF										No evidence of orienting towards equity
NT/NU	✓									Cultural safety position statement
YK	✓	✓	✓	✓	✓		✓			Anti-racist language, some accountability measures

[6] Total Equity Competencies (TEC) abbreviations: ACK (acknowledging), ART (articulating), COM (committing), KNO (knowing), FRA (framing), INV (involving), DEV (developing), ACT (actioning), EVA (evaluating). See table 5.1 for full definitions of each TEC. (Quebec was not reviewed)

Table 5.4

Key Concepts Found in Provincial Practice Standard Documents

Concept	YT	NT[1]	NT[2]	BC[1]	BC[2]	AB[1]	AB[2]	SK[1]	SK[2]	MB	ON[1]	ON[2]	ON[3]	NB[1]	NB[2]	PE[1]	PE[2]	NS[1]	NS[2]	NF[1]	NF[2]
Cultural competency	✓								✓			✓			✓				✓		✓
Cultural humility		✓		✓		✓		✓	✓	✓	✓		✓	✓		✓		✓		✓	✓
Cultural safety		✓		✓						✓	✓		✓	✓		✓		✓		✓	
Culturally safe environment	✓	✓	✓	✓		✓		✓	✓	✓	✓			✓	✓	✓		✓	✓	✓	✓
Social justice		✓		✓		✓		✓	✓	✓	✓			✓		✓		✓		✓	
Health disparity, (in)equity		✓		✓		✓		✓		✓	✓		✓	✓		✓		✓		✓	
Colonization or colonialism				✓																	
Racism		✓		✓		✓				✓	✓			✓		✓		✓		✓	
Oppression & privilege																					
Power		✓		✓	✓	✓		✓		✓	✓	✓	✓	✓		✓		✓		✓	
TIC		✓		✓		✓		✓		✓	✓			✓		✓		✓		✓	
TVIC																					
Truth and Reconciliation		✓		✓		✓		✓		✓	✓			✓		✓		✓		✓	

List of Documents by Abbreviations:

(YT): Yukon Registered Nurses Association. (2019). Standards of practice for registered nurses.

(NT[1]): Registered Nurses Association of the Northwest Territories and Nunavut (2019) Entry-level Competencies for the Practice of Registered Nurses.

(NT[2]): Registered Nurses Association of the Northwest Territories and Nunavut (2019) Standards of Practice for Registered Nurses and Nurse Practitioners.

(BC[1]): British Columbia College of Nurses and Midwives. (2021). Entry-level competencies for registered nurses.

(BC[2]): British Columbia College of Nurses and Midwives. (2020). Nurse practitioner and registered nurse professional standards.

(AB[1]): College of Registered Nurses of Alberta. (2019). Entry-level competencies for the practice of registered nurses.

(AB[2]): College of Registered Nurses of Alberta. (2013). Practice standards for regulated members.

(SK[1]): Saskatchewan Registered Nurse Association. (2019). Registered nurse entry-level competencies.

(SK[2]): Saskatchewan Registered Nurse Association. (2019). Registered nurse practice standards.

(MB): College of Registered Nurses of Manitoba. (2019). Entry-level competencies (ELCs) for the practice of registered nurses.

(ON[1]): College of Nurses of Ontario. (2020). Entry to practice competencies for registered nurses.

(ON[2]): College of Nurses of Ontario. (2002). Professional standards, revised 2002.

(NB[1]): Nurses Association of New Brunswick (2020). Entry-level competencies (ELCs) for the practice of registered nurses.

(NB[2]): Nurses Association of New Brunswick. (2019). Standards of practice for registered nurses.

(PE[1]): College of Nurses of Prince Edward Island. (2019). Entry-level competencies for registered nurses.

(PE[2]): College of Nurses of Prince Edward Island. (2018). Standards for nursing practice – registered nurses.

(NS[1]): Nova Scotia College of Nursing. (2020). Entry-level competencies for the practice of registered nurses.

(NS[2]): Nova Scotia College of Nursing. (2017). Standards of practice for registered nurses.

(NF[1]): College of Registered Nurses of Newfoundland & Labrador. (2019). Entry-level competencies for the practice of registered nurses.

(NF[2]): College of Registered Nurses of Newfoundland & Labrador. (2019). Standards of practice for registered nurses and nurse practitioners.

A Note About ELC documents. Most provincial colleges had based their ELC documents on the CCRNR (2018) competencies. Some of the more relevant sections of the CCRNR (2018) ELC document is quoted in Appendix C. For provincial RN colleges that had two documents [1] denotes entry-level competencies (ELC), and a [2] denotes standards of practice for RNs. ON had released a new code of conduct in 2023 denoted by ON[3] and this replaced the older version ON[2] that was in use during the initial review.

Part 2: Findings From CHN Interviews

Findings from the CHN interviews were organized thematically into the following areas: CHN's understandings of cultural safety/competency, self-identified training and educational needs, and reflective practices. Table 5.5 below summarizes key elements of these three themes.

Table 5.5

Themes and Key Findings From CHN Interviews Related to Cultural Safety

Themes	Key Elements
Understandings	• Conflicting and competing definitions of cultural safety and cultural competency. • Expressed confusion and difficulty conceptualizing what exactly cultural safety is and how it differed from cultural competency. • Approaches to anti-oppression and anti-racism were informed by TIC and harm reduction philosophies.
Training and Education	• Wanted regular and ongoing training. • Prioritized Indigenous led training. • Practical knowledge and hands on learning was seen as more valuable than theoretical constructs. • Needed time and funding to support their training if it was not provided internally during work hours.
Reflective Practices	• Reflective practice was essential part of practice and developing awareness of problematic assumptions and beliefs. • Problematic assumptions revolved around pan-Indigenous approaches to incorporating culture and over emphasizing trauma at the expense of seeing client strengths and capacities. • Potential blind spots included White benevolence, paternalistic racism and colour-blind racism.

Understandings. A number of conflicting and competing definitions of cultural safety and cultural competency emerged during the interviews. Virtually all participants expressed confusion at trying to differentiate between cultural competency and cultural safety. This confusion was exemplified in the following quote.

> Being culturally competent? I don't know, I don't know if that means being confident in what I'm providing to other cultures or, you know, that I'm doing what's best, I really don't know… I think I'm confused, I mean, and that's kind of sad. (CHN10)

After talking a bit about the contradictions and theoretical debates about the two concepts and the original intent of cultural safety, the same CHN noted about their lack of understandings of cultural competency, "I think we're really good at, you know, like colonization… We're really great at thinking that we know best. When I think, like, we really don't, so, yeah. Okay, that makes me feel a little better" (CHN10). Another participant stated:

> I've never heard of the term cultural competency before, so I don't know what that tells you… I don't even know if I can tell you what exactly cultural safety looks like, except for an ongoing attempt to stop being ignorant to the truth and the history. (CHN4)

Only one participant seemed confident with concepts, and they recalled definitions of cultural safety and cultural humility from a recent training. They described cultural competency as the overarching framework that was inclusive of both cultural safety and humility.

Cultural safety was often described by participants as a minimum standard of not-racist or making people feel safe. This was in contrast to cultural competency described as learning and having knowledge about other cultures, as well as being open and accepting of other cultural healing practices and being prepared to incorporate Indigenous cultural practices and ceremonies

into their nursing care when/if clients requested this type of care. This at times suggested that cultural competency was superior to cultural safety. For example, one participant questioned her understandings and suggested,

> I think cultural safety is…that's a good question… making sure that people feel safe to access your space without any glaring racist stuff going on, you know? So… it's kind of the bare minimum… I think cultural competency is when you nail it, you know? … you provide care that's more... validating of people's identity. (CHN1)

This conceptualization is not surprising based on colloquial understandings of the words safety versus competence. One participant was unique in making the connection between safety and relationship "the word competency means that you must study. I would say there's no cultural competency without safety… you've got to walk the walk first… you have to have those relationships" (CHN6).

Another way that participants commonly conceptualized the difference between cultural safety and cultural competency was that competency was having the requisite theoretical knowledge, and that cultural safety was the outcome of implementing that knowledge in practice. Although, this is contradictory to Ramsden's original conceptualization of cultural safety and her rejection of cultural competency, it is consistent with many ELC documents. ELC documents typically described the importance of creating culturally safe environments, which implies outcome. An example of this conceptualization can be found in the following statement:

> I can have the head knowledge, I can go to school, have the theory, so cultural competency and understanding. But… if I'm not actually putting into practice my cultural competency, it's not going to make it a culturally safe place. (CHN3)

Another participant hesitantly suggested “I guess cultural competency is having an understanding of different cultures… taking the time to learn about these cultures… Cultural safety is that they're able to feel safe in this space with their culture” (CHN2). In both of the previous quotes, participants differentiated between these two concepts by locating competency within a nurse’s cognition, versus safety, which was located either as a space/place (i.e., outcome) or within the client’s emotional state. I argue that there are dangers with this conceptualization because the hegemony of patriarchy, colonialism, and scientific ideals make claims that emotions and feelings are often irrational while cognition is rational, and thus superior. Additionally, using words such as space and place conceptualized safety as an environmental outcome of competency, and negated the relational elements and nursing responsibilities to foster culturally safe relationships with people seeking care.

Cultural competency also implies that nurses must *recognize* cultural practices as different, yet still valuable to the health and wellbeing of others despite their own worldviews that might suggest otherwise. Participants also described the problem of condensing complex and individualized cultures into a simplistic essentialized version or pan-Indigenous approach, which was highlighted in this participants words:

> I still struggle sometimes with making assumptions based on knowing one Indigenous person or one Inuit person, when I meet the next Inuit person, [I think] oh, they've got the same value system… I probably have to catch myself the most, just making generalizations. Because that is comfortable and makes complex things easier. (CHN5)

The problem of making assumptions and essentializing culture was echoed by other participants. A few participants described that they recalled educational materials from nursing school (within the last 3-10 years) that centered White as the unnamed cultural standard and put a few “cultural

considerations" literally in the margins of the textbook which were also problematized and described as "really racist" by a few participants.

Although, the above quotes and uncertainty might suggest that participants were not incorporating cultural safety into their care, this was not the overall impression that emerged during the interviews. Earlier in the interviews I had asked participants to describe their approach to anti-oppressive and anti-racist practices, as well as how they went about building relationships and their caring practices with Indigenous clients. The practices that participants described included a strong focus on building trust, being aware of trauma and colonization, embracing lifelong learning, power sharing, meeting the client where they are and letting the client lead, being open and accepting of cultural practices different from their own, and actively advocating that their organizations are resourced so that they could incorporate Indigenous cultural supports into their care (e.g., bringing in Indigenous Elders, healers and community members to offer cultural activities and healing ceremonies such as smudging and talking/healing circles, providing country food) and being humble enough to not claim to be the expert.

Despite the confusion that questions about cultural competency and cultural safety generated among participants, they had clearly already described practices and approaches that were consistent with Ramsden's (2002) theoretical construct of cultural safety and emphasis on nursing relationships and redressing power imbalances. However, it is significant that phrasing of questions around oppression/racism rather than cultural competency/safety generated more fulsome and confident discussions. One participant described their own perception of anti-oppressive practices with their clients in harm reduction practice as

> challenging those assumptions that float around, and that a lot of us kind of just absorb… for me [it's] a practice where all of the back story, [such as] cultural genocide and…

> super intense intergenerational trauma is always present in my interactions… I'm always conscious of the fact there's so many things that led to this person being in front of me right now in their homelessness and in their poverty, and in their substance use. I'm not taking this individual outside… this mess that's been created. (CHN7)

Notably, oppression is not mentioned in the ELC or practice standards for RNs in Ontario. This conveyed to me that participants were more comfortable and confident in their understandings of anti-oppression learned through their harm reduction work than they were with commonly used terminology found in RN practice documents. An anti-racist or anti-oppressive framework does not negate the importance of culture and participants described that anti-oppression also meant supporting cultural practices.

> Being anti-oppressive in that sense would also mean exploring whatever alternatives make sense for this person and understanding that a lot of our medicines come from, you know, this one side and there might be a whole bunch of other things that someone might need to heal. (CHN7)

My findings described above may have been partially due to CHNs awareness of the impacts of trauma on the health of their clients, their knowledge supporting a TIC approach and the importance of harm reduction philosophies (e.g., meeting people where they're at) to their nursing practice area. Participants described that much of their knowledge about anti-oppression work and learning how to provide better care to Indigenous clients came about from practical on the job experiences rather than from school or courses, which partially explains why what one CHN referred to as "academic lingo" was less familiar. Education needs are discussed next.

Training and Education. Participants all desired more training and education around Indigenous specific cultural safety and the TRC Calls to Action. They described the need for

training to be comprehensive and refreshed often and suggested both formalized mandatory training and that more frequent informal opportunities such as in-services and "lunch and learns" would also be valuable. They felt that explicitly making connections to how they could implement theoretical knowledge into practice was important and that when information was solely theoretical that it was easy to forget.

> You're immersed in it while you're doing it [the cultural safety training] and then how much of it do you retain, because it's not actually out there in terms of your practice all the time… I'm a perfect example of ignorance and that's with me you know doing reading… but it's not nearly enough, it's like a little drop in the bucket. (CHN4)

This same participant suggested that most practicing nurses would not have received training in school and "unless you are seeking it out…[or] you are in an establishment that is forcing you to do it it's very unlikely that you know anything except for orange t-shirt day[7]" (CHN4). One participant compared the need for training to doing CPR and that Indigenous cultural safety or truth and reconciliation training should simply be something that organizations mandated that their employees take once per year. Practical training was seen as important, such as learning about Indigenous Services' NIHB program, and the various community services and supports available to clients. Practical knowledge was important because "that translates into like, literally, can I help you today with this problem you've come here with… yeah, absolutely, practical things" (CHN7).

Participants also described that they had limited educational allowances provided by their employers and that they struggled to make decisions to prioritize cultural safety training over

---

[7] The National Day for Truth and Reconciliation held annually in Canada on Sept 30th is also known as Orange Shirt Day and honors the children who were forced to attend Residential Schools.

other trainings (e.g., wound care or mental health courses). Participants felt that organizations should provide dedicated time and financial support to their staff to take Indigenous specific cultural safety/anti-racist training or simply offer them onsite during work hours. Some participants noted that they struggled when they were finding courses on their own to vet trainings and ensure that they were developed and led by Indigenous groups and not offered by opportunistic White people. “Making sure you're doing training that's not just flashy like oh antiracism, but it's actually… Indigenous run” (CHN2). One participant described that ensuring Indigenous led training was important, but also “tricky, because I never want… racialized people to have to do the double labor of experiencing racism while trying to teach White people how not to be racist” (CHN1). This comment highlights the importance of ensuring Indigenous expertise is valued and always compensated fairly and that Indigenous employees or communities’ groups are never expected to volunteer their time and emotional energy to train White nurses.

Nurses described the importance of taking initiative on their own to read the TRC (2015) report and other books and materials produced by Indigenous authors. Experiential learning was also described as important to their understanding of social justice and anti-oppression work, for example, one participant described the impact of a social justice minded high school teacher that took students to protest a bomb factory and visit a former residential school. Another participant went as a student to help a nursing professor with volunteer run unsanctioned safe consumption sites, which influenced their choice to work in harm reduction. They also noted in nursing school they had very limited exposure to harm reduction practices and theories as well as opportunities to work with Indigenous communities and/or homeless communities.

In addition to learning about colonization and trauma, participants described the importance of taking a strength-based approach and expressed a desire to visit Nunavut or learn

Inuktitut and attend cultural events “to embrace the culture and to learn a little bit so then it's easier sometimes to offer to our clients those things” (CHN9) and that they would like to better understand Indigenous worldviews and connections to land, “if I could speak Inuktitut, that would go so much farther… I've never been to the North… I think that's important when people are so directly tied to their land… I don't have a sense of that” (CHN5). Experiential learning was also noted to come at a cost,

> I feel like the way that I learned was by going up north and making mistakes… I learned at the expense of providing good care and… [Indigenous] people were gracious and generous and kind enough to be like, Hey, this is how you can do it better… I didn't learn that from White people and I didn't learn that from an institution. (CHN1)

Participants also noted the importance of understanding nurses’ roles in colonization and the harms that nurses in particular have inflicted, for example, learning about nurses that worked in TB sanitoria, Indian hospitals or residential schools and the ongoing harms of forced medical evacuations and sterilization. One participant described that as a nursing student they took an in-depth unit in school, but that they mostly talked about the church and government:

> I don't think we talked about [nurses]. If we did, it was a very brief kind of glazing over. But yeah, I think I probably would have remembered that… [as a] nursing student going into nursing. I think it would… have stuck. (CHN10)

Participants described the importance of “weaving” in anti-racism into all of nursing students’ course work and that there were many “missed opportunities” to do more. One participant noted that the SDH were a focus of nursing education, but that they were often presented in a theoretical way and as a list to be memorized with less emphasis on how SDH influenced nursing practices and that the “populational kind of things are noted, but never were they like, it's not

actually being Black that gives you high blood pressure, it's racism" (CHN7). This comment highlighted the importance of integrating CRT and an explicitly anti-oppressive approach rather than approaches such as cultural competency that are perhaps more palatable to White settlers.

Reflective Practices. Self-reflection was raised as an important practice by most CHNs to reflect on their assumptions and biases and to improve the care that they were providing to people experiencing homelessness and Indigenous people in particular. Self-reflection was highlighted as critical to accompany any type of cultural safety or anti-racist training and that information alone was insufficient to ameliorate culturally unsafe care. "I don't know the amount of training that will change people unless you are self-conscious, self-aware and you ask yourself… how am I presenting to this person?" (CHN6). One CHN described trying to be reflective and drawing on co-workers as "sounding boards and buffers" (CHN8) to help check unhelpful assumptions. However, this practice is limited when CHNs' colleagues are often White settlers as well, and this may create a White echo chamber or reinforce problematic beliefs and practices. Most CHNs struggled to identify, with examples from their nursing practices with Indigenous clients, the ways in which they themselves might be deterring access to care, upholding systemic racism, or perpetuating settler colonialism. Most CHNs simply responded that they were sure that they did, but they were unaware of how.

All of the CHNs were very committed to anti-oppressive practice and conveyed throughout the interviews that they genuinely cared about their clients and the problems of stigma and anti-Indigenous racism. However, it is important to consider what areas could be improved upon and areas for growth. As a White settler nurse this required that I not only look closely at the interview data, but also to turn inwards and think deeply about my own potential blind spots, similarly held assumptions and problematic beliefs. Victim blaming, and other

discourses about individualism, personal responsibility, and meritocracy were completely absent in the interviews and this was a positive indication that overtly racist attitudes and negative stereotypes about Indigenous Peoples were probably not prevalent among CHNs in harm reduction. However, the risk of slippage into White benevolence and paternalistic racism is something that I struggle with at times. A Métis CHN noted that "someone could even feel like they are expressing a kindness… but it's actually quite racist" (CHN3). A Black CHN echoed similar sentiments "most people would not want to be intentionally racist to you… it's deeper, it's more culturally imbedded that when people are doing those things, some are not even aware of it" (CHN6). The two statements above sum up how good intentions do not ensure anti-racist practices and the risk that good intentions may become paternalistic forms of racism.

There were also a few comments that risked crossing into colour-blind racism and reflected a possible lack of awareness of implicit bias. For example, a White CHN suggested "I treat all my clients equal. There's no difference" (CHN9). Another CHN similarly stated "I treat them as everybody else. They deserve the same level of respect and empathy. So, whether they are Indigenous or not, they deserve my unbiased, you know attention and care. So I have great experiences with them" (CHN2). A Black CHN suggested the need to treat everybody as a human being and when one gets to know an individual "the skin color will not be there. It will disappear" (CHN6), which also advocated colourblindness. However, this same CHN noted that racism is often not intentional and that a sense of superiority among White people was deeply ingrained in Canadian culture. "You cannot talk about racism without talking about culture because that's the way people are brought up… it's a big part of every human. So before we address racism, we have to address culture" (CHN6). Moreover, they suggested that people were often unaware of their bias, but that in their personal experience as a Black person that non-

verbal cues often betrayed White people's discomfort with interacting with people of other races, which suggests that, in reality, colourblindness is an impossible ideal. Later in the interview they refuted the notion that it was about treating all people the same.

> You have to treat everybody as an individual. Because you say, oh Black people. All Black people are not the same. Oh Indigenous [people]. All Indigenous [people] are not the same. People think differently. People's beliefs are different. (CHN6)

They also stressed the importance of not equating problematic behaviour among individuals with their race. In the next sections, I discuss how cultural approaches were described in nursing documents and I expand on the theoretical weaknesses identified in previous sections above.

Cultural Competency, Safety, and Humility: A Discussion of Key Documents

As previous research has highlighted, anti-oppression work viewed solely through a cultural competence lens has significant limitations (Allen, 2006; Anderson et al., 2003; Bell, 2021; Botelho & Lima, 2020; Bourque Bearskin, 2011; Browne & Varcoe, 2006; Carey, 2015; Curtis et al., 2019; Dekker, 2016; Pon, 2009; Tervalon & Murray-Garcia, 1998). Nursing interventions that use a cultural competency framework to address racial inequities are problematic, because power imbalances remain firmly on the side of the nurse (Ramsden, 2002). Cultural safety attempts to shift this power imbalance, but it has been problematically blended with cultural competency. However, this blending was not the original intent for cultural safety, which emerged as a rejection of cultural competency (Koptie, 2009). Despite, a reluctance to let go of cultural frameworks, my research suggested that these frameworks may not be as useful within some nurses' clinical practices as nurse academics and educators might like. Indeed, the concepts of anti-oppression and anti-racism seemed to resonate more with my participants during the interviews than either cultural safety or cultural competency.

Unfortunately, despite recent attempts to expand the notion of culture to be more inclusive of diverse identities (e.g., gender or sexual identities/expressions, sex characteristics), culture is often conflated with ethnicity (Botelho & Lima, 2020). Concepts that use the term 'cultural' (i.e., cultural safety and cultural competency) may unintentionally privilege attempts to recognize and respect ethnic differences, while obscuring intersectional understandings of oppression (Garneau & Pepin, 2015; Sakamoto, 2007; Wesp et al., 2018). For example, health status, age, (dis)ability, mental illness, and other stigmatized illnesses all influence oppression but are not typically conceived of as part of culture. The reverse may also be true that when intersectional understandings of oppression are incorporated into cultural safety that attention to anti-Indigenous racism (which Ramsden sought to address) may be lost. I would suggest that this may be the case with Principle 2 (i.e., cultural safety principle) in the CNO's newest iteration of their (2023) Code of Conduct. In Principle 2, attention to Indigenous specific cultural safety and framing of inequities around colonization is absent. A focus on relational ethics rather than culture may move nursing beyond a narrow focus on static and essentialized notions of cultural differences and towards more inclusive relationships across multiple diversities. Additionally, Indigenous relational ethics that incorporates a critical Indigenous and anti-colonial lens may help return the concept of cultural safety to Ramsden's (2002) original Indigenous specific concept and intent to address anti-Indigenous racism and health inequities.

Although, the term cultural competency is specifically named in the TRC (2015) Calls to Action, the efficacy of cultural competency as a framework to address racism and discrimination in healthcare is questionable (Curtis et al., 2019; Gustafson, 2005; Mulholland, 1995; Pon, 2009). The term cultural competency was also frequently noted in my website review of nursing organizations, and I attempt to deconstruct and critique its utility to address racism and

oppression in the following section. Similar to CHNs conceptualization of cultural safety as an outcome and/or space or place, CNA's (2018) position statement on cultural competency also described cultural safety as the "goal and outcome" of cultural competency (p.4). They defined cultural competency as:

> the ability of nurses to self-reflect on their own cultural values and how these impact the way they provide care. It includes each nurse's ability to assess and respect the values, attitudes and beliefs of persons from other cultures and respond appropriately in planning, implementing, and evaluating a plan of care that incorporates health related cultural beliefs and values, knowledge of disease incidence and prevalence, and treatment efficacy. (CNA, 2018, p. 3)

The last portion of this definition, "knowledge of disease incidence and prevalence, and treatment efficacy," considered in relation to culture is problematic because it risks attributing higher incidences of certain diseases among racialized groups to cultural practices or presumed biological differences rather than racism. Importantly, nurses must not locate the problem of poor health outcomes within Indigenous Peoples or their cultures. Indigenous status is not a risk factor for disease—racism and settler colonialism are root causes of health inequities. The problem of conflating race with racism as a risk factor for poor health outcomes was also highlighted by participants in my study. Race itself is a social construction without a biological basis, yet as CHNs noted that nursing educational material recently used race to explain higher incidences of diseases such as hypertension and diabetes (Bell, 2021; Hall & Fields, 2012). "While [nurse] researchers still attribute 'race' as an individual-level variable, its only explanatory power is as a predictor of exposure to racism" (Allen, 2006, p. 70). Additionally, the definition seems to

suggest that the efficacy of various treatment options varies between people of different cultures, which is a dangerous assumption rooted in the Western hegemony of scientific knowledge.

Western research, from which nursing disciplinary knowledge stems, often uses a microscope that highlights problems and distorts perceptions of Indigenous Peoples and their cultures as damaged and broken (Bell, 2021; Rigney, 1999; RCAP, 1996; Smith, 2021). The typical voice of nursing textbooks erases the social location of both author and reader. These texts, which represent the nursing discipline, reproduce racial hierarchies with an unnamed White nursing center and sidenotes about multiculturalism (Allen, 2006). Statistics emphasize the level of health and social inequities between Indigenous Peoples and settler Canadians. These statistics require careful positioning around the problem of colonialism to avoid causing further harm (Andersen & Walter, 2013). Statistics regarding disease incidence and prevalence are often stressed by researchers and other professionals as an impetus for much needed change (Eaker, 2021). Unfortunately, these same statistics are also used to justify paternalistic control over Indigenous Peoples. Therefore, I argue that the CNA should explicitly link disease prevalence with exposure to racism and colonization in their definition of cultural competency. This link must highlight systemic oppression and structural violence within Canadian (settler) society as a cause of ill health to avoid problematizing Indigenous cultures.

The CNA described cultural humility as an ideal tool for the self-reflection component of cultural competency. They suggested that both cultural competency and cultural humility are lifelong processes and defined the latter as "self-reflection and self-critique to understand personal biases and to develop and maintain mutually respectful relationships built on mutual trust" (CNA, 2018, p.3). Cultural humility is an important concept to shift nurses' focus from the ways in which the client's culture is different from their own towards reflecting on their own

cultural biases and ethnocentric beliefs. However, similar to cultural safety, the concept of cultural humility also emerged as a rejection of cultural competency and was never intended to be blended with cultural competency. The ANAC et al. (2009) framework also blended cultural competency and safety but offered a relational view of culture that was different from those commonly found in other RN documents on college websites.

The blending of cultural competency with cultural safety and humility may reflect an unwillingness to let go of a concept (i.e., cultural competency) that nursing scholars and institutions have invested significant time and resources into developing and implementing. For example, Campinha-Bacote's (2011) cultural competency framework is frequently cited (including by CNA and CASN). Campinha-Bacote (2019) claimed that cultural competency and cultural humility are not mutually exclusive and attempted to coin a new term *cultural competemility*. Valderama-Wallace and Apesoa-Varano (2020) argued that nursing pedagogy is "content driven and competency based [and] this frames transformative pedagogies as incompatible and untenable" (p.2), which suggested a need to let go of cultural competency and instead focus on critical approaches to address racism and discrimination.

Provincial ELC documents demonstrated a shift away from the concept of cultural competency and towards cultural humility and cultural safety. Although, the term cultural competency was used less frequently in ELC documents they made reference to cultural considerations and awareness of cultural knowledge, beliefs and practices that is consistent with a cultural competency approach. Additionally, the term 'culturally safe environments' in the ELC documents detracts from relational aspects of cultural safety. Documents were more likely to use the term culturally safe environments than cultural safety. Cultural safety was typically only in the glossary and the majority of documents used the FNHA (n.d.) definition that described it as

an outcome. Conceptualizing cultural safety as an environment and outcome rather than focus on relationships may negate Ramsden's emphasis on redressing relational power imbalances between settler nurses and Māori in Aotearoa as a key component of cultural safety; a phenomenon that may be transferable to the Canadian context and the Indigenous Peoples of Turtle Island (North America). With the exception of BC, racism was only referenced in the definition of cultural safety found in glossaries. BC's ELC document was the only one to include a fulsome discussion of colonization. Clearly, there are important shifts taking place as many documents included cultural humility or safety rather than cultural competency, but more work is required to push further into anti-oppression terrain. For example, a meaningful discussion of power was largely absent. All provincial ELC documents (except BC) referenced the TRC without making any reference to colonization and although, this was consistent with CCRNR (2018) it is problematic. As per Ramsden's (2002) formative work, understanding colonization is foundational to enact cultural safety and redress the power imbalances inherent within settler colonial society. Privilege and oppression are also not discussed in any ELC or RN practice standards, this further demonstrates a lack of meaningful attention to power. Therefore, failing to mention colonization and oppression in ELC documents are glaring problems.

The First Nations Health Authority (FNHA) highlighted the need for nurses to assume a learner's stance as crucial to providing culturally safe care.

> To provide… care where those we serve feel safe and respected, we need to be humble enough to admit that we don't know everything about everyone's life experiences, culture and feelings, and that health care providers don't know it all. In other words, we need to listen without judgement, and be open to learning from and connecting with individuals, families and communities for better care. (FNHA, n.d., p. 1)

Ramsden (2002) and Tervalon and Murray-Garcia (1998) similarly emphasized a life-long learning process and argued that competency implied an end state that can be taught, measured, and achieved. Thus, I find it noteworthy that cultural safety shifted within ELC documents towards an emphasis on outcome over process and environment over relationship. A number of participants also conceptualized cultural safety as an environment and outcome. Colloquially, the word *safety* described as a *state* of being protected from harm or other danger (dictionary.com, n.d.), implies outcome. Therefore, this shift may not be surprising. If current conceptions of cultural safety have shifted to outcome and environment, then perhaps, a greater emphasis on relational ethics can shift nurses' attention back to processes and actions to redress racial and other oppressive power imbalances within relationships.

In conclusion, cultural safety is an important concept for orientating nursing towards achieving health equity between Indigenous Peoples and settler Canadians (Browne et al., 2016; Browne, 2017; Curtis et al., 2019). Importantly, cultural safety as envisioned by Ramsden was intertwined with relational ethics (Bourque Bearskin, 2011; Ramsden, 2002). Cultural humility is also an important concept to support critical reflexivity and praxis. However, neither cultural humility nor cultural safety were intended to be blended with cultural competency. A critical theoretical approach to relational ethics is also requisite to analyze and address relational power imbalances between the nurse and person seeking care. In this chapter, I presented findings from my website reviews, which highlighted a lack of progress towards meeting the TRC Calls to Action by nursing regulators. I highlighted the conceptual confusion among CHNs related to cultural approaches. I connect some of this confusion to the nursing literature and documents such as ELCs that also conflated cultural competency, cultural safety and cultural humility. I, like many other scholars (Bell, 2021, 2023, 2024; Hantke et al., 2022; Hassen et al., 2021; Iheduru-

Anderson et al., 2021), argued that anti-racist and anti-oppressive frameworks are more effective tools than cultural approaches to think through problems of colonialism and anti-Indigenous racism that have led to health inequities. Additionally, I suggested that relational ethics are critically important to address power imbalances within relationships.

In the next chapter, I examine progress on the TRC Calls to Action in more depth. I continue, as I have done thus far, to tack back and forth between broader social worlds and arenas to the niche of individual CHNs working in harm reduction. Specifically, I move away from the nursing specific realm of regulatory colleges, which was a focus of this chapter, to focus on some of the legal and regulatory elements (e.g., UNDRIP) within political arenas. I then tack back to the niche of Individual CHNs to explore their understandings of UNDRIP, and their perceptions of progress on truth and reconciliation within their workplaces. Organizational leadership emerged as a key (dis)enabling element towards reconciliatory actions. I conclude with an analysis of nursing codes of ethics/conduct and nursing obligations to act when they witness human rights violations and harm.

Chapter Six: A Call to Action—Now What?

> *It is the very truth of racism that should lead us to question whether qualifications beyond 'Racism is important' are necessary at all, and to consider what we do by making these qualifications. I contend that repeatedly (re)starting from a position in which we justify the conversation concedes too much to the idea that there remains any doubt about the conversation's place in the nursing literature. In grappling with this, we might reasonably ask what the utility of the literature is intended to be; is its purpose to win minds… or is its purpose to move the conversation forward? Freya Collier-Sewell – British Nursing Scholar (2023, p. 7)*

In the previous chapters, I attempted to uncover some of the problems of systemic anti-Indigenous racisms. I highlighted that many of the tools that nurses have been provided are inadequate to think through the problem of racism. However, my intentions throughout this entire thesis, is to not simply expose problematic truths in an effort to convince people that change is required. But rather, I seek to continuously push towards meaningful action. Therefore, I focus not just on the lack of progress within nursing, but I also attempt to better understand the situational barriers to action. Leadership emerged in the interviews as critical to advance truth and reconciliation in CHNs workplaces. I argue that leadership accountability within nursing and within all levels of government are essential to enact meaningful policy changes that can achieve health equity and end Indigenous homelessness and anti-Indigenous racism in healthcare.

In this chapter, I critically reflect on the TRC (2015) Calls to Action, and the ways in which a lack of progress is indicative of systemic racism. Thus far, no official government funded committee has been monitoring progress on the TRC Calls to Action. The Yellowhead Institute and CBC's Beyond 94 have both attempted to fill this gap. In 2023, the Yellowhead Institute deemed that none of the Calls to Action in the area of health (#18-24) were completed and they do not measure or report on partial progress (Jewell & Mosby, 2023). The CBC's Beyond 94 also did not provide a detailed analysis of progress specific to nursing. They briefly identified progress on Calls to Action #18-24 to be mostly organizational commitments without

demonstrating a clear plan of action (CBC News, n.d.). Based on my own review of nursing websites in the previous chapter, I suggest that there is limited and sporadic action taken by respective nursing organizations across the country with few reported plans to enact their commitments, and a lack of measurable progress goals, and/or timelines.

In the following sections, I identify more broadly the lack of progress on the TRC Calls to Action in health. Next, I move from this more systemic analysis to the niche of CHNs social worlds. I present findings from qualitative interviews that describe CHNs perspectives on progress on the TRC Calls to Action and cultural safety within their own organizations. I note that organizational leadership emerged in interviews as the most prominent element that (dis)enabled progress towards truth and reconciliation and nurses' anti-oppressive actions. I conclude with a discussion of nursing ethics and our obligations to act when we witness harm. I highlight some of the ways in which UNDRIP and human rights are critical frameworks for nursing action. I critically appraise CNA's *Code of Ethics* (2017) and the CNO's (2023) recently revised *Code of Conduct*. I explore the concept of social justice, which is found in the CNA's (2017), and ICN's (2021) ethical codes. However, social justice is not part of CNO's (2023) *Code of Conduct* and the CNO code did not have an alternate concept to address systemic level oppressions. Nursing ethics must commit to uphold health as a human right and to uphold UNDRIP, which was codified into Canadian law, and received Royal Assent on June 21, 2021.

Calls to Action—How Are We Progressing?

In the wake of Joyce Eschequan's death, the CNA and other nursing organizations issued statements pledging to uphold Joyce's Principle. These statements suggested racism impacts people's health, and nurses have an ethical obligation to address racial oppression at systemic levels, organizational levels, and at the level of individual nurses (CNA, 2021b). However,

Joyce's Principle was not the first call to action that the CNA and other nursing organizations had committed to uphold. In 2015, the TRC published their final report and 94 Calls to Action for Canadians and Calls to Action #18-24 relate to health and healthcare. The CNA Code of Ethics (2017) and entry level competencies (ELC) developed by the CCRNR (2018) and adopted by most provincial regulatory colleges make mention of commitments to uphold the TRC.

Unfortunately, despite numerous declarations of nurses' commitments to reconciliation, nursing action on the TRC Calls to Action since 2015 has not been swift. Nor have nursing actions addressed any of the systemic issues that continue to harm Indigenous Peoples (Allan & Smylie, 2015; Bell, 2021; Eaker, 2021; Horrill et al., 2022; Phillips-Beck et al., 2020; Viens, 2019). Progress on implementing the TRC Calls to Action are inadequate and some scholars and Indigenous leaders have criticized the utility of the current reconciliation framework altogether. Specifically, nearly a decade after the TRC published their final report in 2015, progress on TRC Calls to Action #18-24 have been limited to none (Jewell & Mosby, 2023).

Under the TRC Call to Action #23 all levels of government must provide "cultural competency" training for all health professionals. Additionally, Call to Action #24, obliges nursing schools to address anti-Indigenous racism and the legacy of colonial violence in Canada through mandatory education on Indigenous health issues, ensure knowledge and understanding of UNDRIP, treaties and Aboriginal rights, and provide skills based training in human rights and anti-racism (TRC, 2015). Arguably, training provided to practicing nurses under Call to Action #23 should be similar to the more comprehensive approach aimed towards students and detailed within Call to Action #24. What these calls do not highlight, and may actually obscure, are that as a self-regulated profession nurses themselves have an obligation to ensure all practicing

nurses (including themselves) have requisite knowledge and skills to engage in anti-oppressive and culturally safe nursing practices.

None of the Calls to Action in health demanded accountability from nurses directly, nor do they highlight professional responsibility as a self-regulated profession. In the previous chapter, I noted limited to no actions among nursing regulatory colleges towards holding their membership accountable to anti-racism and UNDRIP, and implementing mandatory cultural competency training, as evidenced by a review of their websites. Call #23 should have called on provincial and territorial nursing regulatory bodies to ensure training and accountability of their membership, rather than call on "all levels of government" to provide cultural competency training, as this may have created a loophole for both governments and nurses' organizations to shirk responsibility for enacting this Call to Action. For example, on their website the Government of Canada claimed that they have met their obligation to Call #23 by providing cultural competency training to nurses employed directly by the Canadian Government (e.g., employees working in nursing stations operated by Indigenous Services Canada (formerly the First Nations and Inuit Health branch of Health Canada)).

Call to Action #19 called on the federal government in consultation with Indigenous Peoples to *establish measurable goals* towards identifying and closing gaps in health outcomes between Indigenous and non-Indigenous Canadians. A lack of data to measure progress is a significant but remediable barrier to completing Call to Action #19, and it is unconscionable that, in the intervening years since the TRC finalized its report, the first small step towards health equity (i.e., setting measurable goals) remains incomplete (Jewell & Mosby, 2022). Healthcare organizations including CHCs and harm reduction organizations must also prioritize collecting race-based data to support goal setting and evaluation of equitable access to care within their

own spheres of influence. However, as CHNs described previously their leadership had not undertaken the important steps of establishing measurable goals towards equity within their own organizations. Moreover, CHNs suggested that Indigenous people experiencing homelessness did not have equitable access to their harm reduction programs and care. Problems within the social worlds of CHNs are a reflection of systemic and structural problems within broader arenas.

Indeed, even TRC Call to Action #53 that called for independent oversight by a national council for reconciliation, which would be formally tasked with monitoring progress of the TRC Calls to Action, has yet to be fully formed and funded. Bill C-29, *The National Council for Reconciliation Act* was introduced in June 2022. This council is intended to fulfill Call #53 and monitor progress on the TRC Calls to Action. Notably the bill would have granted the Canadian government the authority to appoint two-thirds of the members of the council, contravening the very essence of reconciliation and the intent of Call to Action #53 that called for membership to be jointly appointed by the federal government and national Indigenous organizations (Jewell & Mosby, 2022). Therefore, some Indigenous organizations withdrew their support for the bill (e.g., Inuit Tapirit Kanatami). Conservative senators also expressed that for them to support the bill that it needed to reflect "economic reconciliation" whereby Indigenous communities benefit from natural resource extraction to build wealth and eliminate supposed welfare dependency, which is a capitalist approach that is not mentioned in the TRC (Balaban, 2023). Bill C-29 passed on April 30, 2024, without the significant revisions that were hard fought for by Indigenous groups (e.g., only 3/13 seats are to be appointed by national Indigenous organizations). The Crown-Indigenous Relations Minister still holds significant power over the nomination process for the remaining two thirds of seats. The Yellowhead Institute noted this was problematic given that Gary Anandasangaree (the current Crown-Indigenous Relations

Minister since 2023) questioned the objectivity of Indigenous organizations' own TRC progress measures and Anandasangaree suggested that more Calls to Action were probably completed than Indigenous organizations had claimed (Balaban, 2023). Viewed in this light, then, the way in which Bill C-29 was developed is another example of systemic racism in Canada.

In the absence of any organization formally tasked with monitoring progress, the CBC News monitored progress of TRC Calls to Action on their website Beyond 94 (CBC News, n.d.), Indigenous Watchdog.org, an Indigenous nonprofit, monitors progress on their website, and the Yellowhead Institute, an Indigenous research organization based in Toronto, has also been monitoring progress and publishing reports since 2019. In 2022, the Yellowhead Institute described the "glacial pace" towards completing the TRC's 94 Calls to Action, and raised concerns about the "limits of reconciliation as a framework for meaningful and lasting change" (Jewell & Mosby, 2022, p. 14). In 2023, the Yellowhead Institute suggested that they may stop monitoring progress on the TRC and noted that they have "held the tension of the promise of reconciliation with the actual reality—and are exasperated by the deep chasm between the two and frustrated by the discrepancy between inaction and Canada's fantastical myths of benevolence" (Jewell & Mosby, 2023, p. 5). Symbolic reconciliatory actions (e.g., statements against racism and commitments to "uphold" rather than implement the TRC) may perpetuate the myth of benevolence in nursing, unless nurse leaders, educators and researchers prioritize exposing difficult truths and reflecting on nurses' roles in colonialism and causing harm.

The Yellowhead Institute identified various types of reconciliation including different combinations of symbolic, transformative, impactful, and easy reconciliation efforts (Jewell & Mosby, 2022). They identified settler-centric actions that are easy and impactful, such as apologies, accountability, funding, and data transparencies. However, they argued that forms of

reconciliation that are symbolic and easy are often exploitative, such as performative forms of allyship, while reconciliation that is both transformative and easy is a "settler fantasy" (Jewell & Mosby, 2022, p. 43). The potential for allyship to become performative and exploitative, requires critical reflexivity and consideration about what actions settlers could take to engender authentic solidarity with Indigenous communities. Jewell and Mosby identified land back and justice for Indigenous Peoples to be transformative and impactful forms of reconciliation, which necessarily challenge the rightfulness of settler norms, institutions, and political systems. In the following sections, I focus on CHNs' perspectives of progress on truth and reconciliation within their organizations, and what they perceived to be (dis)enablers to nursing actions against oppression.

Findings From Qualitative Interviews With CHNs

Findings related to truth and reconciliation within the CHN interviews were organized thematically into the following three areas (summarized in Table 6.1): 1) The importance of leadership, 2) Promising practices and implementation, and 3) Policy work and advocacy.

Table 6.1

Thematic Summary of Findings Related to TRC from Qualitative Interviews

Theme	Summary of Findings
The Importance of Leadership	• Expressed concerns about how their organizations were working towards the TRC Calls to action. • Emphasized the importance of knowledge and will among leadership, executive directors, and board of directors. • Desired a road map and organizational plan of action. • Problematized symbolic gestures and tokenistic actions. • Highlighted the problem of organizational silence and leadership being risk averse to using collective organizational power.
Promising Practices and Implementation	• Making country food available to clients. • Bringing in harm reduction focused Indigenous Elders, healers and community members to offer cultural activities. • Reflecting on the TRC Calls to Action and identifying concrete ways to implement them within their own sphere of influence.

	• Hiring Indigenous staff to develop/lead programs and projects.
Policy Work and Advocacy	• Anti-racism policies mostly directed towards overt racism against racialized staff. No other anti-racist policies were identified. • Lacked awareness of UNDRIP, treaties and human rights frameworks and how these might influence advocacy and policy. • Felt disempowered by organizational leadership to influence policy change within their own workplace and to engage in higher and systems level advocacy. • Time, resources and direction were all barriers to engage in policy work, political action and systems advocacy.

The Importance of Leadership

All of the participants described the importance of organizational leadership (i.e., board of directors, executive directors, front-line managers) that prioritized Indigenous health equity. Indeed, leadership emerged as one of the single most important elements towards implementing the TRC Calls to Action. Furthermore, leadership could either enable or disenable CHN's anti-oppressive actions and abilities to effect change. Participants suggested that organizations could be doing much more to ensure Indigenous clients had cultural supports available, and to ensure Indigenous clients and staff felt welcome at their establishments; in addition to, simply providing staff with Indigenous cultural safety and anti-racism training. CHNs raised a number of issues related to their organizations' leadership including silence, tokenism, lack of direction to meet TRC calls to action, lack of desire or will to act, not prioritizing Indigenous supports, lack of knowledge or awareness of what is needed, and not listening to front line staff. CHNs noted that there was also a lack of BIPOC staff more generally and Indigenous staff in particular. CHNs suggested that there was a lack of Indigenous representation on boards of directors and in decision making roles, and that leaders were not doing enough to address the many barriers for Indigenous people with lived experience of homelessness to participate on boards.

CHNs highlighted the importance of leadership and CHNs gave both positive and negative examples of leadership approaches. For example, some CHNs suggested that a few nursing leaders and executive-level leaders had worked hard to make organizational connections and develop relationships with Indigenous organizations. These connections were essential because they could improve information sharing and help connect clients with culturally meaningful services. One CHN described how

> Our ED [executive director] for years was somebody who had worked on reserves and really cared and… reached out to Indigenous organizations and made friendships… I think that we were able to make some changes to make our organization more safe for Indigenous clients and Indigenous staff. (CHN5)

Participants described that organizations' leadership had potential to make significant impacts provided that they prioritized meeting the needs of Indigenous clients and allocated funding accordingly. Cultural supports that were seen by CHNs as important to fund, included bringing in Indigenous Elders and healers, and supplying country food for cultural events and on an ongoing basis to support healing and community engagement. CHNs emphasized that it was important for leadership to also prioritize developing relationships more generally. For example, making connections with other service providers in the hospital were described by CHNs as valuable and these connections made CHNs' work easier (e.g., helping clients to navigate complex systems, spending less time trying to access information for their clients).

CHNs highlighted the importance for front-line CHNs to be given dedicated time to advocate and leaderships' permission to speak out. CHNs also described that systems level actions seemed virtually non-existent at their organizations and if it was happening then they were not being involved in it by their leadership.

> You're [on] your own personal journey of learning about it and I can't say I'm an expert in it… but is it always up to me? No, it should be part on the employer, like, they need to make bigger decisions, work on policies, and actually make things happen. They don't, it's all, like, it's all fluff, you know? (CHN2).

The "fluff" the participant was referring to was largely symbolic actions such as recognition of truth and reconciliation day by wearing orange t-shirts on one day of the year, whilst the rest of the year Indigenous issues were not the focus for organizational and/or leadership's concern. Another participant juxtaposed the change in leadership at their organization, which resulted in positive progress towards the TRC Calls to Action.

> We had this meeting for the Truth and Reconciliation Day… usually it's kind of just this little like, oh yeah, let's take a moment and move on kind of thing, and [the new ED] saw the agenda, and was like, what the hell. She brought in an Elder… like actual content beyond just like patting herself on the back for doing the bare minimum. (CHN7)

The same CHN described that their ED had also sent an email to staff requesting that they all reflect on concrete steps they could take in each of their program areas towards reconciliation. Concrete plans of action were described by CHNs as essential to set organizational direction and provide them with clear understandings of what they as individual nurses could do and also to better understand where they were going as an organization.

Plans of Actions. CHNs desired to engage with the TRC Calls to Action and expressed that as individual nurses they did not fully understand how they could/should engage in anti-oppressive actions and implement the TRC Calls to Action. Participants described wanting their organizations to collectively set goals for truth and reconciliation and to identify a "road map" or framework for their employees to take action.

> Like clear actions, like things we can do rather than just being like, oh we celebrated today. Like, being clear in what we're actually doing to work towards this and that would help me… conceptualize it… it's a big list, but to actually take concrete steps… make it clear and move it into kind of a framework. As a [health] centre, we're going to work towards these [goals], and this is how we're going to do it, just to kind of help break it down in my head. (CHN2)

Additionally, nursing organizations, at the national level (e.g., CNA, CASN, CCRNR) and the provincial nursing regulatory body in Ontario (CNO), have not clearly articulated plans of action to address anti-Indigenous discrimination at individual, organizational, and systems levels. In the absence of clear actions and steps, many participants felt that symbolic actions may make some clients feel welcome and seen, but they could also be tokenistic.

Tokenistic Actions. A number of CHNs raised the issue that wearing orange T-shirts for National Day for Truth and Reconciliation, land acknowledgements and artwork were nice, but largely symbolic gestures. “I wear my orange t-shirt… But at the end of the day, it's a bit, it feels a bit tokenistic sometimes, right? If there's no actual connection with someone that you can actually help, you know?” (CHN1). Symbolic gestures were described by CHNs as problematic in the absence of clear plans of action and implementation of policies to improve culturally safe care and equitable access.

> There is a land acknowledgment and Truth and Reconciliation day, which is like the troupe now, everyone is using it to [show]… we care about this and we donate money blah, blah, blah… but then all the other days of the year what are we doing for Indigenous People… and that’s why I got so upset about [refusing to smudge]… you’re not actually taking the steps. (CHN2)

One participant suggested that leadership were often more concerned about their organizational image and would not speak out against injustices if it might cause internal/external conflicts.

> [They are] just adhering to what the political point of view is in terms of society. It's gotta look pretty… it's a fine line to walk for them to include cultural safety without enabling what they view to be a problem. So, it's really a juxtaposition of what their intentions are, but not necessarily honoring what needs to be done. (CHN4)

A number of CHNs suggested that leaders at their organizations may not have a good understanding of what their obligations towards truth and reconciliation are, or how to increase access to care and improve cultural safety. For example, one CHN described when raising the issue of accessibility for Indigenous clients to programs and services that

> I'd get responses like we have… this piece of art… and it's a very nice piece of art, but… to think the response to let's increase access is we've got a painting on the wall? It kind of shows the lack of understanding of what might be needed. (CHN7)

The word tokenistic was often used by CHNs to describe these easy and symbolic gestures, which were seen as problematic in the absence of meaningful action every day of the year to ensure equitable access to healthcare and promote cultural safety.

Organizational Power and Silence. CHNs all suggested that their organizations should engage in higher level advocacy to ensure Indigenous Peoples had equitable access to healthcare, but that for the most part organizations were not engaging in higher level or systems level advocacy. One CHN passionately described their feelings on organizational silence and that their organization was risk averse to using their collective power for change.

> We are silent, like all the time, we are silent, with regards to everything… any issues pertaining to the clients that we supposedly work for, like we're just silent… [in response to a local issue] the director was like, well, you know, after some discussion, we decided not to say anything. And I was like, I'm not sure what you have to lose here?... it's risk averse, but to an extreme… Whether it's homelessness or Indigenous issues… it's incredibly frustrating because for me, yes, I'm passionate about my work day-to-day, I love my clients, I love seeing people, I love fixing the things that I can and all that stuff. That's great, but those are just band aids, you know? At the end of the day, we're a bigger organization, and there is power in that…in actually affecting policy… that feels like the worst of it, frankly, to just be part of this silence. (CHN7)

This CHN acknowledged their own complicity with the organizational silence, but also faced barriers to speak out against their organization's silence, including limitations imposed by leadership, and not being sure of how to most effectively advocate.

Other CHNs also raised the limits of being bound by organizational mandates and by RN regulatory bodies on their ability to advocate and speak out. Most participants were hesitant to personally take on a professional role to engage in higher level actions towards equity or truth and reconciliation without the support and guidance of their organizations.

> You're kind of bound by the policies of the center that you work in, and also, you're bound by the college, right? And by best practices, so we don't have as much autonomy in nursing as we would like… if you have a boss who doesn't hold those values [equity and anti-racism], you're like up against the wall, you know, like there's not a whole lot that you can do. (CHN3)

Feelings of powerlessness at an individual level were not uncommon. Therefore, collective and organizational power were seen as essential for nurses to be able to engage in effective systems level advocacy and policy work. Despite all of the organizations being similarly sized, a few CHNs felt that their organizations were small and had limited power, particularly as they felt hospitals were given higher funding priorities within the arena of Ontario healthcare. Meanwhile other CHNs felt that their organizations were large enough to make an impact and were a locus of political power. All of the CHNs felt that the organizations that they worked for had considerably more power than individual CHNs working on the front lines and also felt that their organizations should be doing more to speak out against racism and oppression.

CHNs noted that anti-racism often took a back seat to what they perceived as other conflicting and competing priorities of organizations (e.g., the overdose and housing crises). CHNs felt that there was a lack of resources and funding for community healthcare, mental health and harm reduction care in general, which highlights the need for political leaders at all levels of government, to also prioritize the rights of people experiencing homelessness and Indigenous people, in particular. Additionally, CHNs suggested that funding problems were exacerbated by a lack of community support for harm reduction and homelessness programs (NIMBYism) and appeasing city councilors, residents, and business owners in neighboring communities often took time away from advocating for other issues. Despite the many challenges, CHNs described a number of promising practices and steps that their organizations were taking towards implementing the TRC Calls to Action and promoting cultural safety.

Promising Practices and Implementation

CHNs described having a strong desire to engage with the TRC Calls to Action and support Indigenous cultural practices, beliefs and healing modalities. They described some of the

ways in which organizations were engaging in promising practices that included bringing in Elders and Indigenous healers, budgeting for and purchasing country food to share with clients on a regular basis, supporting Indigenous staff to take the lead on harm reduction projects and program development, hiring practices that supported diversity, development of an anti-racism policy, voluntary anti-racism training, and mandatory TRC training that was provided during work hours and was Indigenous led, and/or paying for and supporting additional Indigenous cultural safety training with paid time off to attend. However, not all of the organizations were implementing all of these promising practices at once and greater collaboration, such as idea and resource sharing between organizations would be beneficial. A few CHNs described the resource challenges among smaller (relative to acute care) community health organizations and collaborating with other organizations would help ameliorate resource issues.

CHNs at one organization described that their executive director had sent an email prior to the National Day for Truth and Reconciliation that requested all staff read the TRC Calls to Action, reflect on them in relation to their practice and program areas, and identify what they could do within their own sphere of influence to make programs more culturally safe. “Our new executive director put out a request and a call to really specific action in terms of each program coming up with a plan… [and] some goals to work towards increasing cultural safety… with like deadlines” (CHN7). The request was fairly recent and they were hesitantly optimistic with the momentum but were also waiting to see when and how this request would be followed up on, and whether plans would be actioned in a timely manner. This leader’s action-oriented request is an important first step towards implementing TRC Calls to Action. However, developing action plans should also include Indigenous advisory and evaluation. CHNs at another organization described that their organization had brought in an Indigenous consultant to evaluate their

programs and identify areas of improvement. Another participant described having “focus groups with First Nations clients and Inuit clients and Métis clients to really say like, what do you need for you to feel safe in our settings?” (CHN5). The steps taken by these different organizations are both complementary and important, which ideally should be taken in concert to ensure staff are taking on leadership towards truth and reconciliation by identifying areas of improvement, but also seeking feedback from and involving Indigenous communities.

Supporting cultural practices/beliefs and healing modalities were seen as essential by CHNs. Only one CHN (who was at a different organization than the others) felt that their organization did not prioritize Indigenous cultural programming, and thus had nothing available to support Indigenous clients or make them feel welcome. All of the other CHNs described to varying degrees that their organizations were supporting Indigenous cultural practices by bringing in Elders and healers. The importance of which was exemplified in a number of quotes, for example, one CHN described cultural services that were brought to their organization by Indigenous outreach workers a few days a week:

> it was really impactful and really incredible. The spiritual and emotional and mental healing, I think that was observed… and verbalized by the clients, was so profound and so impactful. I really wish that that could be more widespread. (CHN8)

CHNs at a different organization described that they were able to provide country food regularly and that their organization tried to always have a freezer stocked so that it was available whenever it was needed, “food is so soothing for all cultures, like it's so important, and if they don't have access to the meat, or resources, or the capacity of cooking, or they don't have the knowledge… but yeah, definitely a priority or it should be” (CHN9). CHNs at this same organization also described that their organization had partnered with an Indigenous healer and

that it was an organizational priority to ensure monthly healing circles in all programs and that resources were available to help get clients out to her healing lodge outside the city.

All of the participants noted the importance of having Indigenous staff, but that there were few Indigenous staff, and a few CHNs suggested that their organizations had virtually all White staff. One participant described that a pilot project offered a chance to build a more equitable and inclusive space under the leadership of an Indigenous HCP.

> We just had a vision to reach marginalized groups, in particular Indigenous women so we … set a priority to reach this group. We have a higher percentage of Indigenous people accessing our [program]… because that was our vision, you know. Unfortunately, [they] left and we haven't been able to take on any new clients because it's been really tricky with finding providers. (CHN3)

This vignette also highlights the challenge of sustaining vital programming with staff shortages and funding cuts for harm reduction across the country. These challenges may be particularly acute in the context of pilot programs, which might be seen as more expendable because they haven't been operating for as long as other programs.

Policy Work and Advocacy

CHNs felt they had little power to enact changes within broader healthcare systems and power to change oppressive socioeconomic political systems and structures that led to homelessness was felt to be virtually non-existent. CHNs tended to locate their power to enact changes within their individual interactions with clients and described that they often felt disempowered by leadership to make changes at an organizational level. This quote exemplifies the sentiments expressed by virtually all CHNs: "On a day-to-day level and maybe just within

individual interactions, absolutely. I can implement different things on my end, but I'm not sure that I have the power to make any actual changes to the program or system" (CHN10). Despite feelings of powerlessness, most CHNs agreed that they should still try to influence policy and work towards organizational and systemic changes. A few participants described that their organizations had implemented anti-racism policies and mixed feelings emerged around this type of policy and the ways in which it was implemented at an organizational level.

Anti-Racism Policies. Organizations may tout zero-tolerance anti-racism policies as evidence of their commitment to take action against racism. However, CHNs described that zero-tolerance policies in their workplace were typically used to address client behaviours that would likely not be tolerated regardless of whether the policy was in place or not. Many organizations (e.g., clinics, hospitals, banks) already have zero-tolerance policies for physical violence and verbal abuse of any nature. Therefore, zero-tolerance anti-racism polices that focus on overt racist comments and verbal abuse may be somewhat redundant and are not a novel form of anti-racist action. Importantly, zero-tolerance policies against overt racisms are not the only type of anti-racist policy. Policies that uphold Indigenous rights and work towards ameliorating racial inequities are essential types of anti-racist policies.

Additionally, CHNs and their organizations' leadership must identify and address more insidious forms of institutionalized racisms within their own organizations including the problem of inequitable access to harm reduction care. While discussing zero-tolerance policies versus culturally safe care one CHN questioned: "How do we actually care for this population in a way that they want to be cared for?" (CHN10). They went on to contrast with zero-tolerance policies "It's more of a you can't say this and you need to be aware of other people's feelings and I think that's great, but we could do better" (CHN10). Anti-racism policies were typically used to protect

racialized staff from overt racism and verbal aggression and participants did not describe any incidences of policies being used to address staff behaviours towards racialized staff or clients. Organizations must give greater consideration to the kinds of policy changes and staff trainings that would protect people from more insidious nursing behaviours that may deter access to care, such as culturally unsafe care and microaggressions. Furthermore, zero-tolerance policies are unlikely to be effective against more subtle forms of racism including paternalistic racism and White benevolence, and they are certainly not effective against the problem of deeply entrenched and normalized White racialized behaviours that uphold systemic racism.

Most of the CHNs at some point in the interview made the connection between racism and lack of education. They suggested that people generally lacked education, and awareness, or were simply ignorant to histories of colonization and that this led to racism.

> I think part of it is obliviousness, right?... this systemic thing where you don't really learn about it in… [any level of school]… Like if you grow up in a community that… is super white, unknowingly racist in like a microaggessiony kind of way that just has these assumptions about different groups of people. It's hard to unthink that or unlearn that or unpack that if no one extends that to you. (CHN1)

Despite increasing information about residential schools in the media and schools, unfortunately, negative stereotypes and victim blaming continue to persist in society and healthcare is no exception. Education may be requisite to helping White people better understand colonization and systemic racism; however, it is not the only intervention that is needed. The idea that ignorance is primarily what leads to racism and hate are commonly held assumptions that some race scholars disputed. For example, Kendi (2019) and Bonilla-Silva (2021, 2023) both argued that anti-racist policies aimed to level unfair advantages (e.g., affirmative action and DEI

policies) will undo racism much faster than education. One CHN who is Black described that affirmative action policies in education and the workplace are ineffective in the absence of changes that address the underlying social and political structures that disadvantage certain groups across the lifespan. “But those are the barriers [SDH] that you don’t see. Yes, if there’s a policy that can address those barriers [there could be equity], yes. But who is going to make those policies?” (CHN6). They highlighted that political and organizational will are barriers to anti-racist policies that would alter the balance of power between various groups in society.

(dis)Empowerment and Policy Work. A few CHNs described having power within their organizations to make program and policy changes, but this largely depended on leadership and organizational support to empower their front-line staff. Internal organizational level advocacy also took up a lot of time and energy despite being relatively small organizations in comparison to hospitals. Some CHNs described “fighting for years” (CHN4) to address certain issues or that “most of the advocacy it’s been internal, because there’s been like so much… to fight against” (CHN7). Some of the issues that CHNs described fighting against were inequitable access to care, culturally unsafe practices at the institutional level, and lack of cultural supports.

Even while acknowledging their privilege and power as White RNs, CHNs noted that there were differences between being allowed to voice concerns and actually being listened to by people with power to enact change. CHNs questioned whether any of their advocacy efforts would lead to lasting change, for example, “I feel like I have a voice that is heard when I advocate for these needs, but I don’t feel that it goes anywhere…. They hear you out, but then nothing really happens” (CHN4) and another participant described how “I love to send my letters to the MPs and MPPs. Do I get a response back? Not really…[but] our clients sometimes just

need somebody to be the voice for them, you know?" (CHN3). CHNs noted that change could be small and imperceptible and efforts should still be undertaken as individuals.

> It's like going by the river… and there are snail shells everywhere and you look [and think]… I'm not going to make any impact, but if you're able to throw 5 back into the water, although it's not seen, but I think it has an impact. (CHN6)

Advocacy as lone individuals is likely to be far less effective than community advocacy efforts, and most CHNs expressed that higher level policy/systems advocacy should be done collectively at the organizational level. CHNs all agreed that they needed to harness organizational power and should therefore speak in a unified voice about the issues impacting their clients.

Some CHNs described signing petitions or writing letters, but no-one reported attending marches, rallies, protests, speaking to media etc., as noted by the following statement:

> Have I done a great job as a nurse to be up on Parliament Hill and be banging down the doors about housing and water. No unfortunately, like I have definitely signed some petitions. But you know I believe it at my core. (CHN5)

The majority of CHNs noted that they had little to no involvement in systems level advocacy because of their personal limitations and commitments outside of work. Participants expressed that systems level advocacy was something that currently did not happen during work hours and that they would need to undertake it as an unpaid extra. Therefore, they described barriers to systems level advocacy and other political actions to include the amount of time they had available outside of work, and balancing family obligations and everyday life (e.g., being a single mom, housework). Emotional drive was also a barrier to systems level advocacy and political actions as exemplified by the following quote:

> I'm not that fighter, but I work with a lot of fighters and… I mean that in a positive way like the people who will make that time and put in that extra mile to advocate outside the workplace. So I admire that greatly. (CHN4)

Emotional drive may also have been impeded by the perception that CHNs felt that they would be engaging in political action as a lone individual outside of work, rather than being part of a team/organizational effort. A few CHNs expressed interest in participating in higher level advocacy or political action if they had dedicated work time, a plan or road map for action, and a network of people to advocate with.

Being at the right tables were also highlighted as requisite to effective advocacy and that leaders and other decision makers needed to provide RNs with more opportunities to participate and be at the tables. Another CHN noted that although they were not engaging in political action, they believed that CHNs were well positioned to engage in systems level advocacy to address Indigenous homelessness and promote Indigenous rights in healthcare.

> [CHNs] have time to actually sit down and talk with people. Because if I'm in the hospital, we wouldn't be having this conversation, right? Yeah, so I think advocacy will start in the community and these are the people that really have the loudest microphone to yell… write letters, push and pull and yeah, so I would think community nurses don't have to shy away from it… Hospitals like, come, get to work. Get out, next person… our clients we see them every day. (CHN6)

This last comment also raises an important point that relationships were a key driver of advocacy for many of the CHNs interviewed and emotional connections with their clients were a motivator and enabler for action. Bringing this point into greater focus may be necessary to promote a shift

from advocacy *for* vulnerable clients towards more advocacy *with* clients for their own needs and to build more powerful networks within vulnerable communities.

Indigenous Rights in Health Policy and Advocacy. UNDRIP and human rights frameworks are essential to the kinds of policy work and political action requisite to ending Indigenous homelessness and addressing discrimination of Indigenous Peoples in healthcare. Most CHNs had very limited understandings of UNDRIP and the ways in which human rights could or should inform and support their harm reduction work. During a discussion of treaties and the TRC Calls to Action, one CHN noted "I don't think a lot of people understand [treaties] or what kind of land we're seated on… that they lived here for time immemorial and here we are on their land. I think that [knowledge] is super important" (CHN3). However, this perspective about treaties and land was a relative outlier. The question of how treaties, UNDRIP, and human rights frameworks related to their nursing practice, typically resulted in confusion among the vast majority of CHNs that participated in interviews. For example, one CHN expressed "I think [long pause]… well, I would like to have more knowledge about treaties… I guess human rights is like, everyone's treated equal, and like equity, I don't know, yeah, I don't know" (CHN2), how that influences practice.

None of the CHNs verbalized the connection that not having shelter and the criminalization of people that are homeless are human rights' violations. Nor did CHNs highlight that stolen land and broken treaties were particularly relevant to the problem of Indigenous homelessness and health inequities. However, despite the importance of human rights approaches to harm reduction work, CHNs' confusions were not surprising. The CNO has not yet incorporated UNDRIP, treaties or human rights frameworks into their policy and practice documents; therefore, many Ontario nurses in general may not have been exposed to these

frameworks in relation to their nursing practice. Neither has the CNA incorporated UNDRIP or treaties into their most recent (2017) *Code of Ethics for Nurses.* Moreover, given these knowledge gaps, I felt it was important to delineate within this thesis some of the ways that UNDRIP and treaties could or should inform nursing ethics and CHNs work with Indigenous people experiencing homelessness, which I do in the following sections.

The Ethics of Witnessing Harms and Human Suffering

Community health nurses that work in harm reduction with people experiencing homelessness witness first-hand the harms and human suffering that occurs as a direct result of human rights violations (e.g., the right to healthcare, food, shelter, sanitation, an environment free from violence and abuse, access to essential and lifesaving medications). Therefore, it is important to think through nurse's ethical obligations to act when one witnesses human rights violations and human suffering and harm. Ethical codes such as the CNA's (2017) *Code of Ethics* should help guide nurses in their actions. The TRC suggested that protection of all human rights and promotion of Indigenous specific rights as enshrined in Canadian Treaties and UNDRIP are the essence of reconciliation. Therefore, knowledge of the above as well as relational ethics and community engagement may be foundational for anti-oppression work in nursing. UNDRIP is a legal framework that has been ratified into law in Canada, and thus nurses are obligated to uphold Indigenous rights and implement UNDRIP as it applies to their nursing practices and within their healthcare organizations. Inequitable access to care, lack of cultural supports and healthcare that are not free from anti-Indigenous racism are all in violation of UNDRIP.

UNDRIP, treaties, and human rights more generally, should also be incorporated into nursing's ethical codes because they offer important frameworks for nurses to advocate for healthy public policy and more ethical and just social systems. Unfortunately, UNDRIP may be

poorly understood by many Canadians, including nurses. Additionally, as evidenced in my interviews, most CHNs lacked awareness and understanding of how human rights, UNDRIP, and treaties could or should inform their nursing practices with Indigenous people experiencing homelessness. Therefore, in the following sections, I attempt to provide a brief overview of these important frameworks. I conclude with an analysis of nursing codes of ethics/conduct.

Health, Housing and Healthcare are Human Rights

The TRC deemed UNDRIP to be a critical framework for reconciliation and Call to Action #24 highlighted that nurses need to have skill-based training in human rights and greater understandings of UNDRIP and treaties. Although, some nurses may dismiss the relevance of these understandings to clinical practice or argue human rights training falls within a political or legal realm outside the purview of nursing (Downey, 2020; Tisdale & Symenuk, 2020). I wish to draw attention to the linkages between the structural and social determinants of health and upholding existing treaties and UNDRIP. The determinants of health are undeniably within the purview of the nursing discipline. Additionally, health, housing and healthcare are all basic human rights that are particularly relevant within CHNs social worlds because many of the people that CHNs aim to serve do not have access to these basic human rights.

Determinants of Health. The WHO (2010) makes important distinctions between social and structural determinants of health. Structural determinants of health (e.g., racism, colonialism, sexism/patriarchy, capitalism) include social and economic systems and policies, which are influenced by current societal norms and values and their historical continuities with the past (Etowa & Hyman, 2022; Heller et al., 2024; WHO, 2010). Structural determinants of health are upstream factors that influence downstream social determinants of health including income, education, occupation, social class, social capital, and the most downstream determinants of

health such as lifestyle and behaviours, healthcare access, and environmental, material, and psychosocial circumstances (WHO, 2010). The downstream determinants of health exert more direct influences on health outcomes, and unfortunately, their impacts on health are more visible to nurses in clinical practice than structural determinants. For example, nurses can easily identify which behaviours such as substance use or eating junk food may lead to poor health outcomes, but they may not understand whether or not a particular policy will lead to increased health disparities among Indigenous Peoples. Heller et al. (2024) used housing justice as an example and suggested that attention to social stratification and power imbalances was requisite to any actions aimed towards health equity. They argued that the structural determinants of health (as the WHO (2010) intended) were inherently political; however, their systematic review found that in the intervening years since the WHO differentiated between social and structural determinants of health that the two concepts were being conflated and depoliticized (Heller et al., 2024).

Unhealthy behaviours among impoverished Indigenous communities and other marginalized groups including people experiencing homelessness are often highly scrutinized by Canadian (settler) society (Andersen & Walter, 2013; Benoit et al., 2019; Benoit et al., 2003; Eaker, 2021; Goodman et al., 2017; Thistle, 2017). Unfortunately, the visibility of social determinants (e.g., lifestyle and material circumstances) and relative invisibility of structural determinants (e.g., systemic racism) may lead nurses to blame individuals for poor health outcomes rather than identify structural violence as the principle cause of health inequities (Horrill, 2021). Actions towards eliminating health disparities are most impactful at the structural level (Etowa & Hyman, 2022; WHO, 2010), which makes policy work and human rights based approaches essential to nursing practice (Olson & Pauly, 2021; Pauly, 2005; Tisdale & Symenuk, 2020). Human rights frameworks also have potential to be used for political action against public

policies that cause harm at the intersections between homelessness and substance use (e.g., seeking court injunctions against enforcement policies that lead to encampment sweeps or against policies that crack down on public drug use in an attempt to 'move people along' when no affordable housing or shelter space is available to move people into).

Human rights frameworks based on the United Nations' landmark 1948 *Universal Declaration of Human Rights* (UDHR) typically include protections against discrimination and also aim to ensure access to basic necessities of life including housing, food, and the right to live in an environment free from violence (e.g., child abuse, war, violence against women, UN, 1948). The link between human rights and the structural determinants of health clearly points to why UNDRIP, treaties, and human rights training are included in the TRC Call to Action #24, specifically directed at nursing and medical students. Additionally, TRC Call to Action #18 calls for all levels of government to "acknowledge" that Indigenous health disparities are "a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties" (TRC, 2015, p. 3). I argue that nurses must do more than *acknowledge* the cause of problems, they must understand links between government policies, health inequities, and (un)healthy behaviours. Furthermore, nurses must uphold health related human rights by advocating for systems level changes (CNA, 2017; Dion Stout, 2012; Downey, 2014, 2020; ICN, 2021; Tisdale & Symenuk, 2020).

Relevance of UNDRIP. UNDRIP Articles 21, 23, and 24 are relevant to healthcare and homelessness, in particular. UNDRIP Article 21.1 states that "Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, … housing, sanitation, health and social security" (UN, 2007, p.9) and Article 24.1

states that “Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services” (UN, 2007, p. 9). Systemic racism and nurses’ behaviours that deter access to healthcare should be viewed as direct violations of UNDRIP and human rights. Numerous reports and research studies described racism and discrimination in Canadian healthcare (Allan & Smylie, 2015; Benoit et al., 2019; Eaker, 2021; Goodman et al., 2017; Phillips-Beck et al., 2020), which suggests that nurses frequently violate UNDRIP articles 21.1 and 24.1.

Canada is in direct contravention of UNDRIP Article 24.2 that states “Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right” (UN, 2007, p. 9) because federal and provincial governments have not yet set goals to identify, let alone close, gaps in health equity as per TRC Call to Action #19 (Jewell & Mosby, 2022). Therefore, nurses should consider how they can support Indigenous Peoples to hold governments accountable to UNDRIP Article 24.2 and TRC Call to Action #19. Rectifying injustices related to colonization and racism are key themes within UNDRIP that directly relate to the WHO’s (2010) structural determinants of health. Structural determinants of health drive Indigenous health disparities. Nursing ethical codes at national and international levels call on nurses to uphold social justice and advocate for the elimination of health disparities through action on the determinants of health (CNA, 2017; ICN, 2021).

UNDRIP calls for Indigenous sovereignty and control over social, economic, and environmental development in accordance with their cultural traditions, knowledges, and philosophies (UN, 2007). Indigenous sovereignty relates to health equity in many ways. For

example, Indigenous control over land and resource development impacts determinants of health at the structural level through economic benefits and environmental protection of Indigenous food and water systems. Research has also shown Indigenous control over developing and maintaining various institutions within their own communities (e.g., criminal justice, education, health, child welfare) results in improved health outcomes (Chandler & Lalonde, 2008; Whitehead et al., 2016). For example, Chandler and Lalonde (2008) identified five community level protective factors against First Nations youth suicide including securing title to First Nations traditional lands, evidence of securing rights to self-government, band councils consisting of at least 50% women, community control over education, police, child welfare, and healthcare delivery, and presence of facilities to preserve language and culture. Chandler and Lalonde's work, which analyzed disparities in suicide rates among First Nations communities, demonstrates why implementing UNDRIP is critical to achieving health equity. The protective factors listed above clearly relate to UNDRIP Article 23, which states "Indigenous peoples… have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions" (UN, 2007, p. 9).

Paternalistic racism is exemplified by settler refusals to relinquish control over Indigenous health and social programs in direct contravention of UNDRIP, and despite evidence that Indigenous control is often more cost efficient and impactful than settler government interventions (Ansloos, 2018; Chandler & Lalonde, 2008). Importantly, nurses' commitments to reconciliation must include support for Indigenous sovereignty over healthcare (i.e., UNDRIP Article 23) through policy and advocacy work. Fully, implementing UNDRIP would arguably be one of the most effective ways to ameliorate Indigenous disparities in health and homelessness,

in Canada. Despite these clear benefits, settler governments and the general public are resistant to recognizing Indigenous People's legal rights and often violate, not only UNDRIP, but basic human rights as well, as evidenced by high rates of Indigenous homelessness.

Recognition and Rights

The Yellowhead Institute identified five barriers to reconciliation including systemic racism, lack of resources dedicated to reconciliatory actions, paternalism, symbolic reconciliation as exploitation and performance, and prioritizing the public (i.e., settler) interests (Jewell & Mosby, 2022, 2023). The politics of truth and reconciliation tends to rest on the struggle for cultural recognition as well as political and legal recognition of Indigenous rights (Coulthard, 2007). In Canada, the recognition of Indigenous Peoples and their human rights have occurred in principle, for example through signing UNDRIP. Arguably, the failure of the Canadian state to put recognition of UNDRIP into action through policies partially results from a failure of many Canadians to bear witness to that which is beyond recognition. Many Canadians have minimized the trauma and suffering of Indigenous Peoples, possibly because the violence that occurred inside of residential schools and other violent interventions (e.g., reserves and pass systems) are beyond comprehension. Arguably, this failure/refusal to bear witness to Indigenous experiences has led to the refusal of many settler Canadians to recognize the actions of the Canadian state and other actors (e.g., Catholic and Protestant churches, trading companies, British monarchy) as both genocide and an imperial occupation of stolen Indigenous lands (Jewell & Mosby, 2022; Rumford-Rodgers et al., 2022). The whitestream narrative that settlers are the rightful inheritors of wealth and privilege is necessarily disrupted when people accept Indigenous counter-narratives that settler colonialism was a violent process that led to genocide and Indigenous dispossession of their land and culture. However, settler Canadians may never

fully understand (i.e., recognize) the trauma of colonization because this cognitive capacity is inconsistent with European settler colonial worldviews about land and relationality.

Plausibly, a lack of recognition of Indigenous experiences leads to a lack of compassion among settler Canadians and a refusal to support reparations and policies that would enshrine Indigenous rights. UNDRIP was adopted by a majority of UN member states in 2007, but Canada, New Zealand, Australia and the United States all objected to UNDRIP and Canada did not officially remove its objector status until 2016. UNDRIP was not adopted into Canadian law until June of 2021. After consultations with Indigenous groups and with a timeline imposed by the federal government's *United Nations Declaration on the Rights of Indigenous Peoples Act* an action plan for 2023-2028 was released in June of 2023, almost sixteen years after UNDRIP was adopted by the UN (Government of Canada, 2024). In 2019, Bill 76 was introduced by MPP Sol Mamakwa to adopt UNDRIP into Ontario provincial law. Bill 76 passed 2nd reading in 2019 and was referred to the Standing Committee on General Government. To date Bill 76 has not received royal assent in Ontario (Legislative Assembly of Ontario).

This sluggish pace of implementing UNDRIP clearly suggests a majority of settler Canadians lack recognition and respect for Indigenous rights. Therefore, a logical philosophical starting point for reconciliation in nursing might begin with theories of subjectivity related to recognition as a basis for ethical relationships. Indeed, recognition, respect, and rights are explicitly described as key components of Ramsden's theory of cultural safety. However, political action may require a shift in focus from cultural recognition to the ethical act of witnessing that which is beyond settlers' capacity to recognize. In much of Oliver's work, she critiqued mutual recognition as the basis for ethical relationships and called for an ethics of witnessing that was founded on the dialogic of addressability and response-ability with another

and I return to Oliver's theory in chapter 8. I now turn towards Indigenous relational ethics and the importance of treaties, which must be interpreted through Indigenous relational worldviews.

Treaties and Relational Ethics

The TRC Call to Action #24 calls on nurses to have greater understandings of treaties in Canada. UNDRIP also calls for states to respect and uphold Indigenous rights affirmed in existing treaties and agreements between Indigenous Peoples and settler states. The original Māori conceptualization of cultural safety also highlighted the importance of understanding and honoring treaties to close gaps in health between settlers and Indigenous Peoples (Ramsden, 2002). Treaties in Canada are not a singular document. Multiple treaties were negotiated with the Crown at different points in time and by diverse Indigenous groups across vast territories. The eleven Numbered Treaties extend across northern Ontario to British Colombia and up into the Northwest Territories, other territories are also covered by treaties such as the Treaty of Niagara (Starblanket & Hunt, 2020). Although, a fulsome discussion of treaties is beyond the scope of this paper, the connection between health and treaties is important to nursing practice. Treaties must also be interpreted through the lens of Indigenous relational ethics and worldviews and I provide a brief overview of relational ethics here before returning to treaties, *Medicine Chest* agreements and healthcare. Canadian nurses have legal obligations to uphold Treaties and the provisions within them (Craft & Lebihan, 2021; Dion Stout, 2012; McCallum & Lux, 2022).

Indigenous Relational Ethics. In my overview of relational ethics, I wish to avoid a pan-Indigenous approach. Despite the vast diversity of Indigenous cultures around the world, and within various Indigenous strands of relational ethics, there are some overarching commonalities that stem from relational worldviews and connections to the land. I will describe these commonalities first, and then provide some culturally specific exemplars from the literature. I

want to draw attention to the importance of relational worldviews to understanding treaties and to support an ethical stance for nurses. I humbly offer a summary of my understandings of Indigenous relational ethics in the section that follows but encourage settler readers to assume a learner's stance and to read the works of Indigenous scholars for themselves.

Notably, Indigenous scholars from diverse cultural backgrounds have worked to articulate Indigenous theories and research methods (Battiste, 2016; Chilisa, 2012; Ermine, 2007; Ferrazzi et al., 2019; Kovach, 2009; Porsanger, 2004; Smith, 2021; Wilson, 2008), including many Indigenous nursing scholars (Best & Stuart, 2014; Bourque Bearskin et al., 2025; Dion Stout, 2012; Dion Stout et al., 2021; Downey, 2014, 2020; Fraser, 2022a; Kelly et al., 2023; Kelly & Chakanyuka, 2021; Lowe et al., 2022). They have borrowed and adapted each other's Indigenous knowledges and at times worked together across cultures to produce a robust and comprehensive body of academic scholarship. These scholars have articulated common themes within critical Indigenous paradigms, while still respecting differing worldviews, epistemologies, and culturally specific ethical protocols. Commonalities included relational ways of knowing and connections to land, spirits, and ancestors; decolonization and resistance to ongoing colonization; importance of stories within oral cultures; and a relational ethic that demonstrates accountability to *all my relations* and places community needs first (Barlo et al., 2021; Hart, 2010; Healey & Tagak, 2014). *All my relations* include land, animals, people, ancestors, and spirits, it does not just refer to familial or blood relatives.

A relational worldview and the importance of storytelling are two fundamental and inter-related aspects of Indigenous epistemology that have been articulated at length by Indigenous scholars (Battiste, 2016; Chilisa, 2012; Ermine, 2007; Ferrazzi et al., 2019; Kovach, 2009; Porsanger, 2004; Smith, 2021; Wilson, 2008). This body of scholarly work may have theoretical

and practical relevance to clinical practice and advance nursing knowledge in profound ways. For example, storytelling through sharing circles, healing circles, and traditional ceremonies have been established as a healing modality in many Indigenous cultures since time immemorial (Barlo et al., 2021; Kovach, 2009; Lavallée, 2009; Wilson, 2008). CHNs highlighted the healing that they witnessed through the use of healing circles and cultural ceremonies within their own organizations with and for their Indigenous clients. A study by Lowe et al. (2022) in the US also demonstrated the efficacy of a healing circle intervention to reduce substance using behaviours and improve wellbeing among Indigenous young adults with complex trauma.

Despite the similarities between some Indigenous cultural beliefs and practices. All Indigenous cultures are unique. Indigenous scholars have incorporated their own Indigenous knowledges and values into ethical frameworks and research protocols. For example, Barlo et al. (2021) incorporated Australian Indigenous concepts and protocols around yarning or the telling and sharing of stories with the Indigenous research concept of relational accountability. Specifically, they draw on Bundjalung Peoples' words and protocols for yarning at 6 different levels, from *Junaa* (informal conversation) to *Gayi* (formal knowledge transfer between Elders). A framework that supports narrative elicitation that is ethical, democratizing and intentional is also important to building trusting relationships within nurse-person relationships.

Closer to Ottawa, Anishnaabe scholar, Nicholas Reo (2019) draws on his cultural knowledge to expand the concept of relational accountability using Anishnaabe teachings of *inawendiwin*. "Inawendiwin is a way of relating to spirit and to one another that honors the interconnectedness of all our relations—kina enwemgik. Relationships based in inawendiwin teachings are respectful of the individual, as well as the integrity of the collective" (Reo, 2019, p. 68). My study highlighted that CHNs need to move from solely individual level foci towards

greater community engagement and care, which ideally brings together relationships between multiple individuals into a stronger collective network focused on healing and well-being at the community level. CHNs, including myself, may struggle to identify ways to engage in greater community level care, particularly given the primacy of individuals within White settler North American worldviews. Indigenous relational ethics may offer CHNs unique guidance to support their efforts around community engagement and community level healing and care (Kelly et al., 2023; Kurtz, 2011; Kurtz et al., 2017).

Inuit Qaujimajatuqangit (IQ) or Inuit knowledge has been incorporated into research ethics by Inuit and by non-Inuit researchers in collaboration together, and more specifically, they incorporated Inuit societal values or IQ principles such as *Pijitsirniq* serving family and community; *Piliriqatigiinniq* working together for a common cause; *Inuuqatigiitsiarniq* respecting others, relationships, and caring for people; *Tunnganarniq* fostering good spirit by being open, welcoming, and inclusive; *Aajiiqatigiinniq* decision-making through discussion and consensus (Ferrazzi et al., 2018; Ferrazzi et al., 2019; Rand, 2020; Wilson et al., 2020). These concepts bring into focus the need that CHNs articulated for power sharing and shared decision making as part of their anti-oppressive practices and to engage clients in their own care in ways that actually meet their needs.

My exemplars above are mere snippets and do not do justice to the vast Bundjalung, Anishinaabe, or Inuit knowledges. Clearly, relational ethics should incorporate Indigenous knowledges specific to the Indigenous cultures that nurses are working with. CHNs also problematized the tendency to make generalizations about Indigenous cultures and pan-Indigenous approaches to providing cultural supports within their organizations. CHNs were aware the Indigenous people that they served came from a wide variety of cultural backgrounds

from across Canada and wished that supports could be more culturally specific, but that resources were limited. Learning about culturally specific ethical protocols is requisite for nurses prior to visiting an Indigenous community as a guest to provide nursing care or conduct research. However, in urban settings with considerable diversity and with Indigenous Peoples that originate from many different communities and cultures, nurses may find it much more challenging to be culturally specific. In this instance, nurses require a broader understanding of relational ethics, cultural safety, (de)colonization, and a commitment to learn about various Indigenous worldviews and cultures as one encounters them in nursing practice.

Importance of Treaties to Health and Wellbeing. Starblanket and Hunt (2020) suggested that provided existing treaties are interpreted through an Indigenous lens, "treaty can help us re-imagine new and healthy forms of relationships, new possibilities" (p.16). Therefore, treaties may offer a relational framework that is complementary to UNDRIP for anti-oppression work in nursing. Nurses may gain insights into relational ethics and Indigenous perspectives of health and wellness through learning about treaties. However, nursing education must be grounded in Indigenous interpretations of treaties. Furthermore, oral histories described Indigenous Peoples' intentions when they entered into treaty agreements with the British Crown (Battiste, 2016; Starblanket & Hunt, 2020). Arguably, these oral accounts capture more accurately the agreements that were made in comparison to one-sided accounts written in English by Europeans that were economically motivated to find legal and often coercive means of dispossessing Indigenous Peoples from their lands and resources (Battiste, 2016).

For example, Treaty 6 was unique in that it contained a written *Medicine Chest* clause; additionally, Indigenous Nations entered into other Treaties based on oral agreements that included similar provisions for guaranteed, free and unfettered access to medical treatment (Craft

& Lebihan, 2021; McCallum & Lux, 2022). Infectious diseases brought from Europe were having dire impacts on Indigenous populations and their leaders were rightfully demanding the provision of Western medicines that could aid in treating these foreign illnesses. Indigenous leaders viewed Western medicines as complimentary to their existing healing practices and they did not advocate for these Treaty provisions because they felt that Western medicine was superior or would replace their Indigenous medicines (Drees, 2013). *Medicine Chest* provisions have been the subject of much legal debate as provincial and federal governments have fought to eliminate their legal obligations to provide medical care for Indigenous Peoples (Craft & Lebihan, 2021; McCallum & Lux, 2022). For example, the government attempted to argue in court, based on a literal interpretation of the written medicine chest clause in Treaty 6, that this clause was no more than an outdated obligation for a first aid kit to be placed in the home of every Indian agent to be used at the sole discretion of the agent (McCallum & Lux, 2022).

The federally administered Non-insured Health Benefits (NIHB) program is regarded by some as an extension of the medicine chest clause; however, government has repeatedly taken the position that NIHB was a benevolent policy decision and not a Treaty obligation (McCallum & Lux, 2022). NIHB is overly bureaucratic and onerous on patients and HCP, restricts funding to a set envelope, and does not provide free and unfettered access for all Indigenous Peoples. Coverage is restricted to Status First Nations, Inuit (must be recognized by an Inuit land claim organization) and children under 2 years of age whose parent is NIHB eligible for medical treatments, devices (e.g., wheelchairs, eye glasses) and prescription medicines not covered by provincial health insurance or employment-related health insurance plans (McCallum & Lux, 2022). Therefore, many Indigenous people do not qualify for NIHB and some medications and treatments (e.g., physiotherapy) are not covered. Essential medicines and uninsured treatments

are cost-prohibitive for Indigenous families and communities experiencing intergenerational poverty as a direct result of Canada's racist policies (Alfred, 2009).

Starblanket and Hunt (2020) described the need for a *politics of life* in the interpretation of treaties. They described that treaties were not simply land transactions, nor were treaties intended to be a static document to ensure basic survival for Indigenous Peoples, but rather, Elders and other community leaders negotiated treaties with the intention of being living documents that were to evolve ensuring future generations flourished and that the land could sustain everyone (including settlers) indefinitely. A relational perspective conceptualizes treaties as "socially and politically situated life-giving relationships" (Starblanket & Hunt, 2020, p. 17); furthermore, "by invoking the sun, water, rivers, grass, and even in some contexts, the rocks and mountains, Indigenous peoples emphasized an understanding of human relations as ever-lasting, growing, and flourishing" (Starblanket & Hunt, 2020, p. 10).

Relational ethics are critical to interpreting treaties. Treaties were used between various First Nations prior to contact with Europeans and these diplomatic practices were entwined with relational understandings of survival as enmeshed with their environment; therefore, treaties ensured that people and everything surrounding them would remain healthy and flourish in the future (Battiste, 2016; Starblanket & Hunt, 2020). This is the essence of perspectives of health and wellbeing that flow from relational worldviews common to many Indigenous Peoples around the world (Hart, 2010; McCubbin et al., 2013). Treaties were negotiated by Indigenous leaders to ensure that future generations could "turn to them in their efforts to maintain a high quality of life. State neglect of this very important dimension of treaties is even more glaring in moments [of crisis]" such as the Covid 19 pandemic or homelessness (Starblanket & Hunt, 2020, p. 9).

Nursing Codes of Ethics and Indigenous Rights

The following section will compare and contrast the CNA (2017) *Code of Ethics* with the ICN (2021) *Code of Ethics* and the CNO *Code of Conduct* released in 2023 (these codes are all the most recent ethical codes currently in effect for these three organizations and will simply be referred to as Codes). The CNO state on their website that their (2023) Code is different from the CNA (2017) Code because it "is a provincial document and that [it] reflects the legal framework and healthcare climate in Ontario" (CNO, 2023, para 3), which may imply that CNA's (2017) Code is not relevant or doesn't apply to RNs in Ontario. CNO does not provide links or refer nurses to CNA or ICN Codes on their website. I argue RNs in Ontario must be familiar with all three Codes even if the CNO's (2023) Code is the only one that RNs are obligated to follow from a regulatory standpoint. Codes are intended to be both regulatory and aspirational (CNA, 2017).

Social Justice. Social justice figures prominently in the CNA (2017) Code, which is adopted or referenced by most provincial nursing colleges (except CNO) as part of RN practice standards and ELC documents. Social justice is also a core nursing value in the ICN (2021) Code. The CNA defines social justice as

> the fair distribution of society's benefits and responsibilities and their consequences. It focuses on the relative position of one social group in relation to others in society as well as on the root causes of disparities and what can be done to eliminate them. (2017, p. 25)

This definition draws attention to oppression at the systemic level and is discussed by the CNA in relation to advocacy. Social justice is an approach to address population level inequities as compared to cultural safety, which is more targeted to power imbalances within individual nurse-person relationships. Therefore, social justice is an important framework for CHNs and public health nurses that often engage in nursing care at community and population levels and may

engage in more advocacy and policy work than front-line acute care nurses. I argue that CNO's (2023) Code, which doesn't mention social justice, lacks a framework to meaningfully address human rights violations and the lack of healthcare access, which occurs as a result of structural violence and systemic racism against Indigenous Peoples and other marginalized groups experiencing oppressions such as homelessness, mental illness and substance use.

Social justice according to both the CNA (2017) and ICN (2021) Codes are a key value for nursing, but for social justice to be effective in anti-oppressive work, it must be enacted (Browne & Reimer-Kirkham, 2014). Social justice requires nurses to understand the social and structural determinants of health, health equity, and Principles of Primary Health Care, which are most impactful at the policy level (CNA, 2010; Varcoe et al., 2014). In clinical practice most nurses (as individuals) have little control over developing healthy public policy unless they specifically do policy work at various levels of government. Therefore, social justice is typically enacted by individual nurses through their collective involvement with nursing organizations that engage in advocacy work to influence government policy, such as professional associations, healthcare organizations, and/or unions (Etowa & Hyman, 2022).

At the level of nurse-person or nurse-family relationships, social justice may be used as a lens that fosters understanding of how social circumstances limit or constrain choices and influence healthy or unhealthy behaviours (Varcoe et al., 2014). Theoretically, social justice should result in nurses having greater awareness of health inequities experienced by Indigenous Peoples at the population level, and less victim blaming and more compassion for Indigenous persons and their families. Browne and Reimer-Kirkham (2014) "question whether, in the enthusiasm for the ideals represented by social justice, nurses have developed taken-for-granted assumptions and blind spots that limit how we… enact social justice" (p. 21). They argued social

justice frequently endorses a politics of difference that risks solidifying identities centered around being the oppressed, vulnerable, or marginalized and that unhelpful binaries occur as a result. Additionally, binaries and essentializing differences risks perpetuating the phenomenon of othering (Browne & Reimer-Kirkham, 2014).

Valderama-Wallace and Apesoa-Varano (2020) found how social justice was envisioned and taught in nursing schools varied based on professors' race and other social factors. They found that White nurses were more likely to focus on 'vulnerabilities' that without a discussion of power and privilege perpetuated othering and stereotypes. White nurses also tended to conflate social justice with multiculturalism. Meanwhile, BIPOC nurses were more likely to incorporate a critical approach that sometimes jeopardized their own social position as faculty. These variations in teaching shed light on nursing's "hidden curriculum" and problematic focus on professionalism that is bound up with Whiteness; furthermore, these "behavioral norms built around avoiding differences in opinion and conflict avoidance limit the capacity to engage in the complex and reflexive dialogue necessary for a commitment to social justice" (Valderama-Wallace & Apesoa-Varano, 2020, p. 9). Nurses require guidance on how to effectively enact social justice and engage in political advocacy in order to move beyond the symbolism of ascribing to social justice as a core nursing value without meaningful and effective action (Browne & Reimer-Kirkham, 2014; Etowa & Hyman, 2022; Havenga et al., 2018; Stievano & Tschudin, 2019; Tisdale & Symenuk, 2020; Valderama-Wallace & Apesoa-Varano, 2020).

Human Rights and UNDRIP. Human rights and discrimination are mentioned in CNA (2017), CNO (2023), and ICN (2021) Codes; however, the link between social justice, human rights, and Indigenous rights frameworks (i.e., UNDRIP and Treaties) must be made explicit in future iterations of these codes. Human rights are discussed throughout the ICN (2021) Code, but

they do not mention racism, Indigenous rights, or UNDRIP. Researchers have highlighted the importance of human rights within the ICN Codes (Stievano & Tschudin, 2019). However, despite the importance of upholding UNDRIP to Indigenous health around the world, few researchers have highlighted the lack of attention to Indigenous rights within national and international nursing codes (Havenga et al., 2018; Tisdale & Symenuk, 2020). Although human rights are mentioned under the heading of social justice in the CNA (2017) Code connections between social justice, human rights, and Indigenous rights are also not made explicit.

Tisdale and Symenuk (2020) conducted an historical analysis of CNA Codes from 1953-2017. They "contend that the authority of Canadian nursing codes of ethics to uphold human rights within the profession and nursing practice has diminished over time" (p.1078). Tisdale and Symenuk (2020) argued that despite social justice being a core nursing value that the CNA (2017) Code currently lacks attention to human rights. However, the CNO's (2023) Code does not mention social justice at all and simply states that their Code is informed by the Ontario Human Rights Code and lacks attention to how nurses can or must advocate for human rights. Additionally, although the CNO (2023) Code noted that it is informed by the TRC Calls to Action, they do not mention the word colonization or colonialism even once despite an entire principle dedicated to cultural safety. CNO suggested that their Code (2023) was developed to reflect Ontario's provincial legislation, but it never mentions nurses' specific obligations to Indigenous rights to health and healthcare, despite that UNDRIP was ratified into Canadian law in 2021 and in 2019 introduced into Ontario legislation (although not yet ratified into law).

Nursing regulatory bodies should uphold their regulatory role to protect the public and hold nurses professionally accountable for racism and human rights violations that occur in healthcare. Similarly, future iterations of CNA's Code, which is intended to be both aspirational

and regulatory must clearly articulate nurses' obligations to act with regards to advocacy and accountability to uphold and protect Indigenous rights. Given trends within early iterations of CNA's Codes to reference primary sources for international human rights such as the United Nations' UDHR (Tisdale & Symenuk, 2020), the next iteration of CNA's Code should also reference UNDRIP. The ICN (2021) and CNO (2023) Codes also do not reference UDHR. The CNA (2017) and CNO (2023) Codes referenced the TRC, but they do not reference legal frameworks such as UNDRIP, treaties, or Indigenous specific provisions within the 1982 *Canadian Charter of Rights and Freedoms*. Additionally, Tisdale and Symenuk (2020) found that between 1970 and 1991, "the language used to outline a nurse's ethical obligation to human rights weakened despite the immense developments in human rights policy during this period" (p. 1081). Tisdale and Symenuk (2020) described that CNA's (2017) Code used discretionary rather than obligatory language regarding human rights and Indigenous rights, for example, to be aware of, respect or acknowledge Indigenous rights, rather than to advocate or intervene. Future nursing codes must strengthen nurses' awareness of legal conventions and declarations with regards to Indigenous rights, but importantly must clearly articulate nurses' obligations to act (Dion Stout, 2012; Downey, 2020; Fraser, 2022b; Kelly, 2024; Kelly et al., 2023).

Given that codes of ethics are intended to be both regulatory and aspirational, Tisdale and Symenuk (2020) argued that references to human rights within the CNA (2017) Code suggested nursing action is discretionary and falls short of what nurses should aspire to. For example, by using the phrase "respect the special history and interests of Indigenous Peoples" (CNA, 2017, p. 15) instead of naming ongoing colonization "the very 'Truth' that the TRC is 'calling to action' is erased" (Tisdale & Symenuk, 2020, p. 1084). I argue that more radical language, such as *expose settler colonial violence and intervene against anti-Indigenous racism,* would constitute

an ethical and aspirational call to nursing action. Furthermore, truth must come before authentic reconciliation, anti-racism must precede cultural safety and anti-colonialism is inseparable from both reconciliation and cultural safety (Kelly & Chakanyuka, 2021).

In conclusion, this chapter positioned my research within the TRC's (2015) Calls to Action and nurses' ethical obligations to ensure Indigenous rights to healthcare and housing are upheld. I articulated why the TRC may have called for nurses to have human rights and anti-racism training and to learn about treaties. If nurses have greater understandings of Indigenous interpretations of treaties this may in turn lead to greater understandings of relational ethics and relational perspectives of health and wellbeing. Treaties may chart a way forward in nursing, through looking back at the obligations to Indigenous Peoples that settlers and the Canadian State and British crown originally committed to uphold. Ethical codes must reflect the legal environments in Canada and Ontario including human rights, the Charter, treaties made with Indigenous Peoples across Canada, and UNDRIP. Importantly, nurses have power and must hold high aspirations to advocate for Indigenous health equity and housing as basic human rights.

Chapter Seven: From (in)Visibility to Witnessing—A Closer Look at CHNs Struggles

"If you have come to help me you are wasting your time. If you have come because your liberation is bound up with mine, then let us work together." Dr. Lila Watson – Gangulu scholar and Aboriginal activists' group, Queensland, circa 1970s

In the following chapter, I dive deeper into CHNs anti-colonial struggles. I begin to articulate a theoretical framework of nursing actions and relational practices rooted in relational ethics for nursing struggles against colonialism, racism, and oppression. In previous chapters, I highlighted situational elements (e.g., leadership, regulatory colleges, media) external to CHNs that may influence their actions and nursing practices with Indigenous people experiencing homelessness. This chapter tacks back to the niche of the individual, and my objective to identify anti-colonial beliefs and actions among CHNs, and the ways in which CHNs perpetuate, maintain, or challenge colonialism and racism in healthcare. Despite problematic discourses of altruism and self-sacrifice in nursing, helping others is not a sacrificial process.

As Dr. Lila Watson wisely pointed out in the opening quote above, working together against oppressions can be mutually beneficial for all people involved, and work should not be undertaken by White people with paternalistic notions of saving the Indigenous other. Indeed, nurses stand to benefit from breaking down oppressive colonial and patriarchal structures that marginalize the nursing profession through long standing gender power imbalances and unrealistic expectations about self-sacrifice. Maracle (2017) also highlighted these mutual benefits that "If you participate in dismantling the master's house and ending all forms of oppression, you are helping yourself. The sooner Canadians realize that, the better" (p. 49). Nurses may also experience profound benefits from engaging in relational practices. CHNs described that many of their relationships were mutually beneficial, and that relationships with others were a strong motivator to work in community health and harm reduction nursing.

In the following sections, I present interview findings, before returning to extant literature and my theoretical framework to expand and develop these emerging insights. In development phases of my study, I assumed that there were three potential sites for nurses anti-colonial action, the first was within individual encounters between nurses and Indigenous persons (e.g., culturally safe relationships, re-dressing power imbalances); the second was through each nurse's own advocacy work at multiple levels (individual, organizational, community, and systems); and the third site was through collective political actions (e.g., advocacy, policy work, political protest). These three sites, which were explored in interviews, are fundamentally relational and build upon each other. Moreover, relationships are influenced by the broader situation in which they develop. Importantly, social networks are foundational to collective actions requisite to ending Indigenous homelessness and achieving health equity.

A number of nursing practices emerged from the interviews that seemed to be critical to CHNs anti-oppressive work. Internal struggles and challenges within themselves, also emerged as barriers for CHNs to undertake anti-oppressive actions. For example, CHNs at times struggled to see racism and speak out against it. Despite these challenges, CHNs clearly engaged in many anti-oppressive actions and ethical relational practices. These important relational findings were placed into two overarching themes with subthemes, summarized in Table 7.1. The first overarching theme "Struggles From Within Ourselves" included the subthemes: 1) Seeing Racism and 2) Overcoming Silence. The second overarching theme "Cultivating Anti-Oppressive Nursing Practices" was divided into subthemes: 1) Actions Within Relationships and 2) Actions For Others. Themes overlapped and interrelationships between themes were also evident. Power, relationality, and (in)visibility threaded through each of the themes and subthemes.

Table 7.1

CHNs Struggles and Actions: Summary of Themes and Subthemes

Themes and Subthemes	Summary of Key Findings
Struggles From Within Ourselves	
Seeing Racism	• Systemic racism was more invisible and harder for White CHNs to see and respond to than overt racism. • Intersecting oppressions obscured racism. Discrimination related to homelessness and substance use was at times perceived as a race neutral phenomenon. • CHNs tended to locate the problem of racism elsewhere.
Overcoming Silence	• Zero-tolerance policies enabled speaking out, but only against overt racism and tended to reinforce rather than challenge power imbalances between staff and client. • Avoiding confrontation, perfectionism, and fear of "not getting it right" were significant barriers to speaking out. • Silence was an action that maintained power and privilege. • CHNs felt obligations to use their privilege for positive change and reflected on the need to use their voices responsibly.
Cultivating Anti-Oppressive Nursing Practices	
Actions Within Relationships	• Building trust was essential to provide care. • Narrative elicitation, assuming a learner stance, bearing witness, suspending judgment, and shared decision making were key actions within relationships. • Relationships developed over long periods of time and involved frequent check-ins, sharing stories, food, use of humor, and engaging from an authentic place.
Actions for Others	• Behind-the-scenes anti-oppressive actions included systems navigation, care coordination, and individual level advocacy. • Advocacy was often *for* others rather than *with* them. • Tremendous amounts of advocacy towards acute care and other services providers to ensure equitable access to care. • Shared humanity and relationships were common emotional motivations for advocacy.

To expand and develop my emerging themes, I went back and forth between the interview data and extant literature. My analysis of processes and actions drew heavily on the grounded theory aspects of SA. Memoing was an essential analysis tool to develop deeper theoretical insights into emerging findings. I engaged in deep reflections on the kinds of practices (positive and negative) that I have observed within my various nursing practice areas over the years, and at times enacted myself. I also reflected on my observations during my time spent as a harm reduction nurse. I wrote memos about my reflections to develop detailed understandings of relational practices and nursing actions. My theoretical framework and Oliver's (2015) theory of witnessing ethics also drew my attention to a very important relational practice that was emerging in the interview data—the importance of bearing witness to social suffering and harm. This ethical practice allowed CHNs to overcome some of their internal limitations as White settlers who struggled to see and understand racism. Witnessing harm also motivated CHNs to speak out against injustices and overcome their tendencies towards silence. This important practice, which was interconnected with seeing racism and overcoming silence, was one of the key nursing actions within relationships. In the discussion sections that follow, I return to Oliver's theory to expand and develop the concept of witnessing for nursing.

Power cut across all of the themes. CHNs described that they had the most power within individual interactions, which could largely be divided into client focused anti-racist nursing practices (e.g., client advocacy and culturally safe practices when providing nursing care) and staff focused anti-racist interventions (e.g., responding to racism directed at staff). CHNs described that they had power to ensure cultural safety within their own practices and support clients to access care through navigating discriminatory healthcare systems. Power also emerged in findings related to CHNs responses to overt racism, which tended to be client's engaging in

racist comments directed at racialized staff. White CHNs highlighted that zero-tolerance policies empowered them to "call out" or address overt racism among clients, and that they were generally able to respond easily to this type of racism; however, this also underscores some of the problems of power over in nurse-client relationships. Calling out colleagues or other people in positions of authority over them carried a significant risk to CHNs' power and place within their workplace. Power influenced whether or not CHNs spoke out or remained silent against racism. In other words, CHNs might remain silent rather than risk losing their power and would speak out if power would remain firmly on their side. Power was also vital to CHNs' ability to successfully engage in advocacy for their clients. Power sharing is requisite to shift from advocacy for clients to advocacy with them. I turn now to the first theme "Struggles from Within" and the subthemes 1) Seeing Racism and 2) Overcoming Silence.

Struggles From Within

Importantly, CHNs struggled to see and understand racism and they also struggled to break the silence around racism. These were key research findings and support findings from studies described in previous chapters that White silence was highly problematic and must be addressed. Seeing racism and overcoming silence were interconnected struggles.

Seeing Racism

As one CHN highlighted "if you *see* it… it's about speaking up" (CHN2) which underscores the importance of recognizing racism when it occurs. Therefore, recognition of various types of racisms would generally be a prerequisite to action and how CHNs see and understand racism is critical to address the issue in nursing. This theme was one of the key areas where some responses were clearly different between White CHNs and the CHN participant that identified as Black. For example, many White CHNs struggled with conceptualizing and labeling

more insidious forms of discrimination, structural violence and inequitable access to care within their own organizations as racism. Racism, not surprisingly, was much easier for White CHNs to see, acknowledge, and respond to, when it was overt behaviours enacted by individuals (e.g. racial slurs, comments clearly directed at an individual's racial identity). There was also an element of uncertainty among White CHNs and questioning whether discriminatory behaviours were racism or not when a client's race intersected with other stigmatized issues including homelessness, STBBIs, sex work, and/or substance use. White CHNs acknowledged that they at times struggled to see racism and that it could be somewhat invisible to White people because it was not their lived reality to experience racism. That White nurses might not recognize racism as it was happening connects to their relational practices of validating people's lived experiences and the importance of bearing witness to that which is beyond the limits of their recognition based on their own lived experiences of being White.

Invisibility of Racism. All of the participants highlighted that in general systemic racisms and structural violence are root causes of Indigenous homelessness and acknowledged that Indigenous Peoples are disproportionately impacted by homelessness. Several participants highlighted the invisibility of systemic racism and structural violence as one White CHN described "I think they're very systemic, and … for White people, they can be a bit invisible… they're harder for us to notice and see and acknowledge on a daily basis" (CHN1). Another CHN described feeling uncertain about how knowledge of historical harms influenced their nursing practice and their inability to see and understand intergenerational traumas. "I'm not entirely sure how, I guess that affects my nursing practice aside from understanding that they could be suffering from … things that obviously I can't see or relate to" (CHN10). The same CHN also acknowledged that these blind spots and being oblivious or ignorant of racism could negatively

impact the care they provide. “I think through ignorance yes, not intentionally, but you know… just basic ignorance… Sometimes I guess I just don’t think about those things… that definitely can affect our clients” (CHN10).

Seeing Race. Race and racism were sometimes connected by CHNs to people being “visibly” Indigenous and may have led some CHNs to underestimate the number of Indigenous clients that they serve. For example, one CHN noted “yeah, so there’s only, to my knowledge maybe like, people who are obviously Indigenous, there’s probably only a handful” (CHN1), while another CHN from the same organization felt that the proportion of Indigenous clients accessing their program would be quite high based on race-based data collected when the program first started. A CHN at a different organization described that their organization doesn’t collect race-based data and they were often not aware of whether people were Indigenous or not and sometimes felt uncomfortable to ask. “It’s not always immediately really obvious… there’s probably lots of people that are actually Indigenous that I’m not even aware of… they don’t share it for their specific reasons, like they feel it’s going to disadvantage their care” (CHN2). This same CHN and others noted that some additional resources were available to Indigenous clients; therefore, it was beneficial to know if someone identified as Indigenous or not. Albeit CHNs described that additional resources for Indigenous persons experiencing homelessness were still insufficient and often difficult to navigate.

Seeing Problems Elsewhere. All of the CHNs regardless of race were more likely to see racism as a problem occurring elsewhere (e.g., in the ED, inpatient acute care units, medical specialist clinics, dentist appointments, pharmacies, and by police and paramedics) compared to within the social world of harm reduction. This sentiment expressed by virtually all CHNs is summed up in the following quote:

> I feel when they go to hospital there's prejudice because, oh it's just another homeless um Indigenous women. Oh it's another drinker. Oh it's another, you know? So it's mostly when they get out of our universe, like here we try to create a bubble and just center on what they want and what they need. (CHN9)

To some degree, CHNs' perspectives may be correct that there was less overt discrimination in general within harm reduction organizations because of their mandates to serve marginalized populations and philosophy of destigmatizing substance use, homelessness, sex work, etc., as compared to acute care. However, future research would need to explore the perspectives of Indigenous people with lived experiences of accessing harm reduction care in the community to confirm or refute this assumption, and better understand the prevalence and manifestations of anti-Indigenous racism in harm reduction and community healthcare.

All of the CHN's struggled to identify ways in which they may be perpetuating colonialism or anti-Indigenous racism in their own nursing practices. This may in part be due to the ways that racisms are conceptualized as overt prejudice and discrimination, and in the case of Indigenous Peoples, this prejudice often takes the shape of negative stereotypes about substance use and alcohol. Since CHNs were actively fighting against stigmas related to substance use, it is understandable that they believed that these types of racisms were absent in harm reduction. However, as I discussed at length in previous chapters, racisms and White racial behaviours that perpetuate racial inequities manifest in a multitude of ways, and locating the problem elsewhere is a common response and move to claim innocence among White people when they discuss racism. CHNs also might not have been exposed to theoretical tools to think through more subtle forms of racism including White benevolence, White saviorism, and paternalistic racisms.

Intersecting Oppressions Obscure Racism. All of the participants described overt discrimination in healthcare facing all of their clients, regardless of race, related to substance use and homelessness and many CHNs had difficulty teasing out how discrimination might differ for their Indigenous clients. One CHN responded to my question of whether clients had ever disclosed experiences of racism in the following way.

> Oh yeah, all the time, all the time. Yep. On a regular basis. Like often it's from police or emergency departments. I have a lot of clients, Indigenous ones, and you know, non-Indigenous ones that absolutely refuse to go to the ER, refuse to go with paramedics, will absolutely not report anything to the police ever regardless of what the crime is and how bad it is… but in this population that isn't unique to Indigenous folks. I feel like every single one of my clients because of their homelessness and their substance use that is a recuring theme across the board. (CHN1)

Notably, this CHNs initial reaction was to affirm the existence of a lot of racism experienced by their Indigenous clients, but as they progressed in their explanation there was a question of whether the discrimination was as a result of race or social circumstances.

Another CHN also commented that all of their clients "had so much discrimination just because of their lifestyle that the Indigenous factor didn't really factor in on top of everything else. Um I'm sure that it did in their background and their growing up" (CHN4). However, they also went on to describe that building trust was more difficult because of racism "they are not wanting to share the things that they would need to share to get adequate care because it hasn't mattered in the past because all the people saw was their Indigenous status" (CHN4). This same CHN acknowledged that despite having witnessed significant racism in a Northern Ontario city and being Métis themselves that they still probably don't recognize racism all the time when it's

happening. A few CHNs also noted that most of the disclosures from clients related to discrimination was related to their substance use and homelessness and one CHN commented that "I don't know if I've ever had somebody say they're discriminated against because of their race in particular" (CHN3).

I found this ambivalence interesting about whether their Indigenous clients experienced racism on top of all the other stigma and prejudice related to homelessness, and only a few CHNs were unequivocal about discrimination occurring as a result of race. One CHN described having

> really witnessed, I think the precariousness of particularly what our Indigenous clients experiencing homelessness go through, because we do really see our Indigenous client's being more likely to sleep outside and not be in shelters and… have a lot of experiences of racism accessing healthcare. (CHN5)

They went on to describe that "It's things that would never be allowed to happen to a White person... A lot of our Indigenous clients kind of actively avoid the hospitals because they're just like, 'they're not going to take care of me anyway'" (CHN5). Another CHN described the overt discrimination that all of their clients faced, but that understanding racism was still important.

> We love to have the idea that we try to operate from a super non-judgmental lens and a low barrier lens… because our clients … experience that within the systems…but I think it's harder and important to try to pinpoint, um Indigenous folks is, you know, another level [of discrimination] and there's differences and I think it's tricky to like, tease those out, but it does definitely exist. (CHN8)

When I asked in interviews if they felt that discrimination was different for their Indigenous clients, one CHN described it in terms of intersectionality and layers of oppression, in addition to

the stigma of homelessness and substance use that Indigenous people "get slapped with a bunch of stereotypes just different types and layers of racism" (CHN2).

Was That Actually Racism? Although CHNs tended to locate the problem of overt racism and discriminatory behaviours among healthcare providers as a problem that was more likely to occur elsewhere, CHNs did still acknowledge and describe problems within their own organizations that were indicative of institutionalized racism. These problems, described in previous chapters, included inequitable access to care, lack of cultural safety training, and lack of staff diversity, but CHNs seemed hesitant to label these problems as related to racism. For example, one CHN described the lack of diversity at their workplace as problematic, but hesitated to frame the lack of action towards diversity, equity and inclusion as racism.

> I think it's more… insidious little kind of um, where it's not exactly racism… and maybe not specifically towards Indigenous communities, but… many staff have sort of raised some flags in terms of like, everybody who works here is White… and are we even collecting data… and those requests have historically been met with like, uh, just go away… and so is that racism? Like okay, maybe not super directly, but kind of, you know? And it overall sets this tone of like these things don't really matter or are not really important and so that I feel is what's harder to respond to when the whole organization at its core is not prioritizing these things. So it's hard to believe that there'd be a great client experience if the organization itself has that mentality. (CHN 7)

Labeling problems as racism while advocating for changes may have risks, such as people with the power to make changes becoming overly defensive or triggering White fragility. However, identifying problems as racism is also an important element of breaking White silence around racism and ensuring BIPOC peoples feel seen and heard. Another CHN's uncertainty about

racism was evident in the following situation when they were arranging for a client to attend a pharmacy every day for daily dispense of their medications.

> I don't know if it was because of how they looked. So they do appear like they're not White. They do appear to be Indigenous and they are also homeless. We sent them to this pharmacy and they pulled them aside and said 'you can't come to this pharmacy unless you promise that you're not going to steal anything' … I wasn't sure if it was about their homelessness… Like, they didn't dress, like they dressed well, so I don't know if that was an incidence of racism, but that caused them to actually leave and they didn't get their medication… but yeah that could have been due to their race. (CHN2)

Importantly, this CHN's uncertainty about racism did not prevent them from taking action. They had reached out to the pharmacy to complain and were still in the process of dealing with the complaint. However, the importance of recognizing racism cannot be understated as prerequisite to action. CHNs were often not physically present to witness discrimination that their clients endured in other community settings (e.g., banks, pharmacies, dental clinics) and in the hospital setting (e.g., ED, inpatient acute care units, specialist clinics). Therefore, it may be more difficult for CHNs to identify how racism against Indigenous clients manifests differently from stigma related to substance use and homelessness among their White clients.

Overcoming Silence

The following theme describes the many challenges that CHNs experienced with overcoming their tendencies towards silence in the face of racism. At times, anti-racism policies empowered CHNs to speak out, but typically only against overt racism. Moreover, zero-tolerance policies tended to strengthen already existing power imbalances between nurse and client, given that these policies were rarely used against staff or leadership. Power within harm reduction is

incredibly complex and zero-tolerance policies meant that vulnerable clients could be timed out of shelter/housing and healthcare. Perfectionism, avoiding confrontation, and fear of not getting it 'right' were also significant barriers to speaking out. Barriers that were not mentioned may include employment status (e.g., full-time indeterminate, part-time, term/contract, casual) and a lack of union protection. Many CHNs in Ontario, including in this study setting, do not work within unionized environments and lack this protective element when speaking out. Power is bound up with these barriers because engaging in confrontation with peers or superiors, risks losing power (or even their job), as does saying the wrong thing and losing face. Therefore, staying silent was an action that, was not simply complicit with racism, but benefited the nurse as well to maintain power. However, CHNs also described that they had obligations to use their power and privilege for positive change, and reflected on the need to do this responsibly.

Calling it Out and The Power of Policies. CHNs described that overt racism, typically, was clients directing verbal abuse at racialized staff, and they felt confident to *call it out*, in particular when their organizations had 'zero-tolerance' policies for racism. "Like really overt racism, for sure… you can't say that. You need to leave" (CHN7). CHNs felt empowered and obligated by anti-racist policies to act and these policies are important to protect and support racialized staff. But a couple of CHNs also acknowledged that there was a significant power imbalance in calling out overt racism when it was client on staff violence.

> If it was a peer of mine… I think I could still do it but it would be much harder than… clients are coming, accessing services, say something inappropriate or insensitive and then again, the power dynamic is there. You're out of here. You know 24 hours you can come back. Right? There's a lot of power dynamics in what we do. (CHN10)

All of the CHNs suggested that they struggled to respond when it was colleagues engaging in racist remarks, less overt racist behaviours, and/or institutional racisms. Additionally, CHNs need to learn how to recognize and approach the more subtle behaviours and comments among their colleagues as noted in the seeing racism theme earlier in this findings chapter. As one Black CHN noted, the subtle and insidious forms of racism were difficult to navigate.

> But that's not even the worst part of it, you know somebody can call you the N word, you know you're offended, yeah. But… with the way the system is built, it can be very hurtful when people do it in a silent [way]… it's subtle… In the US they just say shit to your face… but in Canada, people are more diplomatic the way they present things and that will make it worse you know? It's harder to navigate. (CHN6)

Additionally, identifying systemic racism is important to anti-racist nursing practices. Possibly even more so than actually calling out overt racism, because action against systemic racism has greater potential to ameliorate racial health inequities and end Indigenous homelessness. Microaggressions and White benevolence perpetuated by staff are an issue whereby zero-tolerance policies may be ineffective, and promoting deeper self-awareness through reflexive discussions and debriefing may be more appropriate. Policies were helpful to empower nurses to speak out against racism when the power imbalance was already on their side. However, policies were largely ineffective in calling out colleagues and speaking out against institutionalized practices and/or organizational leadership.

Avoiding Confrontation. Additionally, a few White CHNs described that they "call it out" as inappropriate without calling it racism to avoid confrontation. "I find that people are not receptive to being called out as racist. Nobody likes that and that is a conversation shutter downer" (CHN1). Another CHN described keeping emotions in check when confronting racism

"so learning how to approach it in a way that's not angry… and kind of be a leader… you want to have a dialogue with someone rather than tell them 'you're racist.' That doesn't come across good for anybody" (CHN2). However, a Black CHN suggested taking a more direct approach. "I'll let you know that I'm angry… [not] sugar coat it... My goal is to get you upset enough so that you always remember it and will refrain from it and that's how my culture has brought me up" (CHN6). Importantly, racialized people should be permitted to express their anger at experiencing racism without triggering White fragility and this CHN was mostly referring to how they approach other staff and this was not necessarily their approach to clients. In a harm reduction setting expressing anger towards clients may escalate an already volatile encounter and lead to harsher penalties/longer timeouts for vulnerable clients.

A number of White CHNs also described that they felt more comfortable supporting the person experiencing racism rather than calling it out. However, one White CHN suggested that racialized staff/peers were in a better position to empathize and support the person experiencing racism. Nurses desire to remove and support the victim instead of addressing the racist behaviour may be an attempt to avoid conflict. CHNs need to increase their confidence and comfort with calling out racism as this is an important action. Silence as discussed throughout this theme was also the predominate form of (in)action among CHNs that was complicit in upholding racism.

Remaining Silent to Maintain Power. Importantly, in the case of speaking out against clients' inappropriate behaviours, the action of calling it out and zero-tolerance policies maintained or enhanced CHN power. Remaining silent could be perceived as an action intended to maintain power. Nurses need to consider how their silence is complicit with racism when they refuse to risk losing their power. Speaking out against a colleague or superior could lead to a loss of power, particularly if one takes a confrontational approach. High expectations of themselves,

lack of confidence and fear of not getting it right also impeded White CHN's willingness to speak out. "I don't have good, in French we say répartie, how to talk back to someone quick, some people are really good and they have perfect attitude… but I'm getting better… because we are doing a lot of advocating." (CHN9). Another CHN also described the challenge of responding in the moment.

> When I witness it? Um, not always… sometimes it takes me a day or two and then I'm like, oh *that,* I needed to do that in the moment. 'Cause you get caught off guard… and sometimes just being brave enough to do it. I mean, which is sad, but it's true. (CHN5)

One CHN suggested that White nurses needed to work through those insecurities and that saying something imperfect was better than silence. "I just try to say something. You just have to say literally anything" (CHN1). CHNs might be deterred from future actions without constructive feedback and positive reinforcement. For example, a debrief may have been valuable for the CHN in the following situation.

> My personality, I don't do well in those types of situations to begin with. I really struggle with that. It takes a lot to kind of… speak up. And even just the other day the way EMS was interacting with one of our clients and it was really hard to watch and my attempts… [it] just wasn't as effective I think as I would have liked. (CHN8)

CHN's colleagues and organizational leadership should consider that opportunities to debrief after dealing with racist encounters are important anti-racist practices that are likely to create positive feedback loops for future action.

Calling out racism or leading educational debriefs should not by default be the responsibility of BIPOC staff, unless they express a desire to do so, and are well supported

during the process. “I feel this is a responsibility as a White person to not make other racialized people do that work [of speaking up and educating other White people]” (CHN1). These sentiments were echoed by a Black CHN who suggested that White people needed to use their power to call out other White people that were engaging in racism.

> I’m a visible minority, I may have to look for… uh maybe you know a colleague or a friend of Caucasian descent that can actually step in and say hey, wait a minute, this is not right. They will have a more powerful voice… It can be hard you know because you might be called the same… and you don’t want to be in that position. (CHN6)

However, this same CHN also highlighted throughout their interview the problem that many White people had a sense of superiority and that racialized people were made to feel inferior in a way that impeded them from capitalizing on their own strengths and power.

Power and Privilege Comes with Obligations. Power was inextricably intertwined with (in)action and silence. Relational power imbalances were evident in CHNs’ advocacy work and within CHNs’ relationships with their organizations and with their clients. However, power was most evident in CHNs’ discussions of silence and speaking out. A number of participants all highlighted that their privilege as White women enabled them and gave them power in many situations that involved advocacy and speaking out.

> Partially my privilege. Not partially, but a huge part of it…. Just being confident in, I don’t know, I guess knowing that people are going to listen to me. You know, I think that’s something that I take for granted too. Yeah, just again having that power. (CHN10)

Power gave CHNs pause for reflection on how to use their White privilege wisely, for example one CHN noted

> I think it's always a bit tricky when you're White, you know, when you're coming from a place of being White, but we definitely call it out… we have zero-tolerance… So I feel comfortable, but I also know where I'm speaking as a White woman. (CHN3)

Many CHNs raised that White privilege enabled them to have their voices heard and listened to by people in healthcare systems, but also hesitated at times to talk about Whiteness in the context of power and privilege. One CHN raised that White privilege enabled them to advocate, "my privilege… you know again as a White woman, I don't have those experiences and [long pause and struggling to find words]… I don't know how to explain" (CHN8).

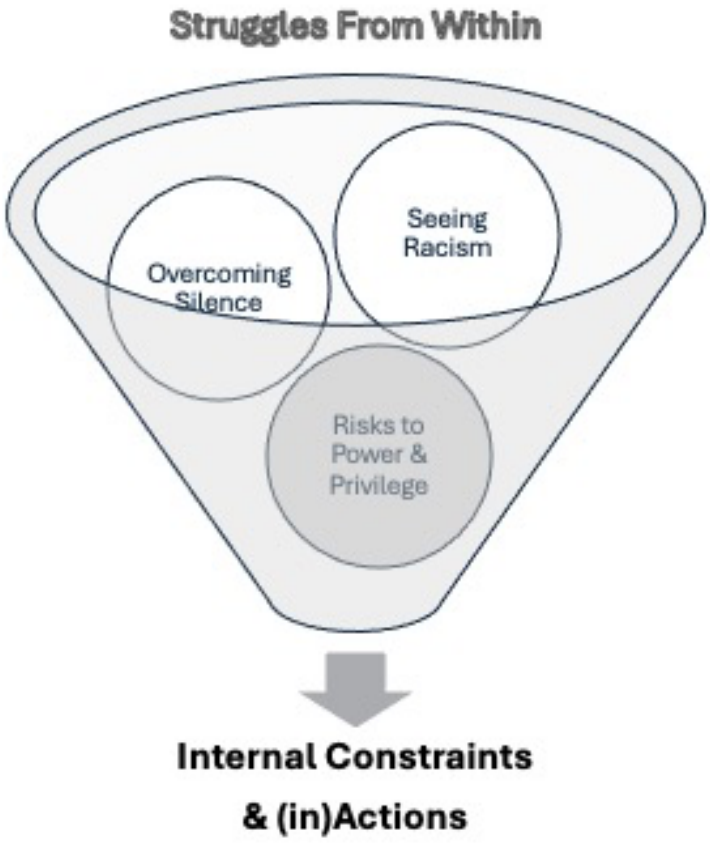
Perspectives on nursing specific power were mixed and discourses of powerlessness are also common in nursing, exemplified by the phrase "*just* a nurse". CHNs described the problems of not being at the right tables, not being given a voice within their organizations, and feeling like their knowledge of organizational and structural issues were not respected by people with the power to enact changes. "Feeling like your voice doesn't matter, 'cause I think sometimes as a nurse you can be like I'm just a nurse" (CHN5). But despite feeling powerless, CHNs felt they had certain obligations, or as one CHN suggested a "right and a duty" as a nurse to speak up for people that may not have as powerful of a voice. "We're very lucky because saying that I'm a registered nurse I'm able to see a lot of things actually change when I sign a document… there's something that comes with being licensed and under a regulatory body" (CHN3). Nurses should be encouraged to include their clients in their advocacy work to share their power and privilege.

In the theme *Struggles from Within Ourselves* (visualized in Figure 7.1), I described some of the struggles around seeing racism that CHNs experienced, and their challenge of overcoming silence in the face of racism. CHNs were hesitant to label a number of situational issues as related to racism, even when they witnessed discrimination against Indigenous clients, or

identified potentially discriminatory policies, attitudes, or practices within their organizations. Power and silence were inextricably intertwined when it came to *calling out* racism. CHNs had some struggles that were clearly internal within themselves. These internal struggles included their abilities to see racism and overcome silence.

Figure 7.1

CHNs' Struggles From Within Themselves: A Visual Summary



The problem of silence may be one of the greatest challenges and blind-spots in nursing and significantly impedes advances in health equity, cultural safety and the elimination of systemic racism and other forms of oppressions. As noted in previous chapters, BIPOC nurses have documented their observations on White silence and the harms BIPOC people experience as a result of silence. They have repeatedly called for White people to speak-up when they witness

racism. Unfortunately, silence persists despite these calls to speak-out and this begs the question: Why? CHNs were aware of the need to overcome silence and desired to do the right thing, but still struggled with speaking out. The interviews barely scratched the surface of this issue and further research is required to understand the complex problem of why CHNs, who were mostly White women, struggled to speak-out/speak-up and the intersecting power/oppressions that fuel silence. Arguably, it is ineffective to demand that nurses speak-out without interventions to support the kinds of (un)learning of deeply entrenched social norms rooted in patriarchy, internalized oppressions, medical hierarchies, White supremacy, and colonialism. Moreover, this (un)learning to cultivate power and break silence will inevitably have profoundly positive impacts among nurses of all racial and gender backgrounds. Despite the challenges of seeing racism and overcoming silence, CHNs engaged in many positive practices within their relationships with clients and took anti-oppressive actions on their behalf. I turn now to actions and practices that were essential to anti-oppressive client encounters and building positive trusting relationships with Indigenous people experiencing homelessness.

Cultivating Anti-Oppressive Practices

Cultivating anti-oppressive practices are critical to struggles against colonialism in nursing. CHNs anti-oppressive practices enacted within client encounters included: narrative elicitation, bearing witness, suspending judgement, and shared decision making. These practices were essential to building a trusting relationship and providing ethical care. These important relational practices will be discussed in the subtheme *Actions Within Relationships*. The practices listed above, which CHNs enacted *with* clients, further informed their behind-the-scenes anti-oppressive work, described in the subtheme *Actions for Others,* which included advocacy for clients, care coordination, and systems navigation undertaken at the individual level.

CHNs described that a lot of their anti-oppressive work was done without the client physically present in the situation and that they struggled to engage in advocacy and action *with* Indigenous people living through homelessness rather than *for* them on their behalf. They also struggled to engage in higher levels of advocacy and political action against all forms of racism and oppression. Situational barriers and the importance of leadership to systems level advocacy were discussed in the previous chapter. Lack of time, motivation, skill, organizational support, not being at the right decision-making tables, and lack of power were described by CHNs as barriers for them to engage in higher level advocacy and political action.

Actions within Relationships

I specifically asked CHNs about how they perceived their relationships with Indigenous clients but asking that question generated mostly superficial and awkward responses. It was this type of question that also generated the notion discussed earlier that *I treat all my clients the same*; and therefore, relationships with Indigenous clients were no different than with their other clients. However, throughout the entire interview a more detailed picture of relational practices emerged organically in response to many questions unrelated to relationships. For example, in relation to a question about how they were responding to racism, CHNs described the importance of validation as a relational practice that built stronger alliances with their clients. Key relational practices within client encounters included narrative elicitation, assuming a learner stance, bearing witness, suspending judgment, and shared decision making. These practices generated much deeper understandings of clients' life situations, clinical needs, and importantly clients' goals of care. These understandings then further informed CHNs behind-the-scenes anti-oppression work including advocacy for equitable care and systems navigation.

Sharing Stories and Taking the Time (Narrative Elicitation). Sharing stories, speaking with people from a genuine place, and taking the time to listen to people's concerns were essential relational practices. However, narrative elicitation was not as simplistic as it may sound, because a lack of trust among Indigenous people experiencing homelessness was a significant barrier for people to open up and share their stories with nurses. Strong bonds between CHNs and their clients took time to form, and sometimes required many interactions over months or years to reach the point where clients would even begin to share their healthcare concerns. Building trust was described by participants as an essential component of their job and that without a trusting relationship they could not provide proper care. Without trust, CHNs often wouldn't even know what care the client needed and wanted for themselves. The following comment exemplified many CHNs' ideas about how they built a trusting relationship with their Indigenous clients, including the 1-year time frame, casual non-clinical approach, and sharing personal stories and food or coffee.

> I'm thinking of one Indigenous guy in particular. He's just starting to trust me, and it's been over a year. I've seen him once a week… And we've had to share food together… have coffee and just chat about nonclinical medical stuff to get to this point where I can be like 'What do you need?'... and he can give me an honest answer. (CHN1)

Without trust CHNs described that relationships were superficial and that clients would tell them "what they think we want to hear… and it's very surface level a lot of times" (CHN10). Therefore, it could be, understandably, very difficult for CHNs to assess mental health, get to the root of substance use problems, and/or encourage clients to take medications unless they first took the time to build trust. Even conducting a proper physical health assessment could be challenging without a trusting relationship.

Time, consistency, meeting people where they are at, setting realistic expectations, and honoring commitments were also seen as essential to building trust. A trusting relationship was described as difficult and time consuming to build and "very easy to break" (CN10). Another participant described that their clients had often listened to service providers about what they were supposed to do to get housing and care and "yet still end up kind of at the bottom. So, there's a lot of frustration that these people were supposed to help me. But they didn't… [so they] don't trust" (CHN2). Daily check-ins and "sticking it out in one place for a long time, even though it's hard" (CHN1) were highlighted by many participants as important to successfully building trusting relationships with their Indigenous clients.

> I spend a lot of time outside before I come in for work each morning because there's a group of Indigenous folks that are always together… I check in with them… and try to engage and try to see how we can get [them] connected to care. (CHN8)

Another participant highlighted that because CHNs get to see their clients daily that

> I've noticed, a lot of people working in harm reduction, it's very transient work because it's a very emotionally burdensome, but I saw that because our clients are estranged from their families a lot, trust is super important and rapport building takes time. I feel it's been very important for them to have a staff member who's stayed. (CHN3)

This quote highlighted the emotional risks that CHNs took when they built relationships, particularly given the risk of losing their clients to premature death from overdose and other poor health outcomes that are a reality of exposure to homelessness. CHNs experienced grief that came with losing the people that they had come to know and care about. However, there was also a sense of duty that many CHNs felt towards honoring their commitments and being accountable to the people that they had developed these more long-term relationships with. Importantly,

relational benefits did not simply flow towards the client at the expense of the nurse's emotional integrity. CHNs described many benefits from being in nursing relationships with their clients.

Assuming a Learner Stance. Learning from clients and reorienting relationships such that the client was the teacher was essential to experiencing some of the relational benefits that nurses described. CHNs described that trust and consistency were requisite to these kinds of mutually beneficial relationships. "Being that point person that stays and that they can build trust with, I've been able to develop really beautiful relationships and learn from them… which is amazing" (CHN3). Assuming a learner stance and listening emerged during the interviews as essential relational practices that deepened trusting relationships, and thus improved care. Assuming a learner stance was also an essential component of narrative elicitation. The stories that clients shared about their land and culture in particular helped CHNs learn and also form stronger bonds. "Just sitting with my clients when they open up and they share… nice stories about their childhood or when they were living out in the bush. It's just nice to connect and hear those stories" (CHN9). They also noted that as relationships deepened with their Indigenous clients that they learned a lot about their client's cultures. Listening to life stories and learning was a very rewarding process. Another CHN described her experiences of connecting with clients as "profound" to simply talk together and "hearing about their encounters with nature, and a way of life that I have no connection with… so lots of gratitude because I've learned a lot" (CHN5). Assuming a learner stance overlapped with other relational practices, for example, it was also essential to the practice of shared decision making, because this practice involved the client as the expert in their care. Therefore, the nurse needed to relinquish the role of expert, and humbly become the learner. Being humble and open was also essential to bearing witness and

suspending judgment. CHNs described that they had to be open to discomfort that came from hearing about and bearing witness to profound human suffering.

Bearing Witness. Bearing witness required deep listening and the practice of suspending judgment. Bearing witness meant believing peoples stories, which the CHNs were often not eyewitness to, and not denying their clients' lived realities. CHNs suggested that practices of bearing witness and validation strengthened emotional bonds and helped clients to trust them; therefore, witnessing could facilitate relational healing. The relational practice of witnessing also gave CHNs greater structural awareness and emotional motivations to speak out against injustices. Bearing witness and validation were described by participants as important responses to racism whether they were eyewitness to the client's experience or the client recounted a story of harm, for example, "I try to validate that that's not normal and that shouldn't be happening" (CHN7). One participant described that they tried to

> be very present, like, physically present here if we're having emergency services come in. I find that there's a lot of advocacy that happens in those situations to prevent a lot of the systemic harms that are being done over and over again. To…provide information, be someone who the client has a little bit of an alliance with and some trust with. (CHN8)

However, most participants described that they were not always eyewitness to the harmful experiences and that "often those experiences are shared in the context of like, I think you need to go to the hospital right now and they say, 'no and this is why…'" (CHN7). Bearing witness as a relational practice required nurses to lean into discomfort and at times risk their own emotional integrity. The emotional challenges of "seeing things that most Canadians just hear about in a story or read about and having faces to those stories and… extreme levels of pain and trauma and having sat with a lot of people through that" (CHN5) was described as an element that both

deepened relationships but also led to a lot of burn out and grief among staff. One participant described that an important part of validation was the practice of sharing emotions “I feel for you. I hear you… and it pains me, right? And together we kind of figure out how to solve it if we can” (CHN6). Bearing witness also meant nurses’ unconditional acceptance, “knowing that their perception is their truth and their reality” (CHN8) and not questioning veracity. As one participant described that “not denying people their lived experience is really powerful and important, you know? Yeah… when people tell me hard stuff, I'm like, I believe you” (CHN1).

Suspending Judgment. CHNs described having colonization and trauma at the back of their minds as a means to suspend judgment of the behaviours that they might be witnessing. Awareness of trauma was particularly important when clients were directing verbal aggression or physical violence towards CHNs or other service providers. One CHN described “I have the good fortune of also getting to work with people sometimes when they’re violent, but then getting to see them when they’re sober and not being triggered… and knowing that’s not who they are” (CHN5). This CHN highlighted the difference that long term relationships made to their understandings of trauma and ability to suspend judgment about violence experienced in the context of providing nursing care. They suggested that other service providers, including police and hospital staff, typically did not have the privilege of knowing a person for a long time through both positive and negative encounters and also knowing their client’s life stories. They believed a lack of long-term relationships may, at times, contribute to bias and judgmental care in acute care and/or policing. Another participant argued that all the training in the world would be ineffective in changing stigma and stereotypes, and thus, relationships were essential to the practice of suspending judgment. “I don't know how we can erase that kind of mindset except in that relationship. One on one. You know, open your mind and say, what I'm seeing are the outside

and I need to know this person" (CHN6). As CHNs became more attuned to their biases, and practiced suspending judgment, they could better understand people's life stories. Suspending judgment allowed for understanding people's social circumstances that constrained their health-related decisions, coping skills, and other behaviours rooted in trauma. Therefore, suspending judgment was requisite to shared decision making.

> I want to very much maintain a client's dignity and their respect, and empowerment… and also really, really not lose focus on them being autonomous humans within themselves, and they're very, very much deserving of that no matter what…and to not fall into the idea that it's just choice. I think that there is a lot of suffering that happens within the folks that we see. (CHN8)

Through suspending judgment, CHNs were also able to glean better understandings of what clients actually needed and wanted for their healthcare and importantly, not judge them for any of their decisions.

Shared Decision Making. A number of participants noted that for deeper relationships and bonds to form that they had to "engage from a really genuine place… not coming as an authority, or coming as an expert, coming as a partner in their care, and being open to a lot of discomfort" (CHN5). Another participant noted that clients were really attuned to people's underlying intentions as a street survival skill and that they could tell "if you're full of baloney" (CHN1). Shared decision making required CHNs to assume a learner's stance. As one CHN described "I want you to teach me about you… I don't want you to feel because I took a course, I know more than you. You have an entire family background. For generations and generations, that you've got inside of you" (CHN4). They went on to suggest that a number of their clients

were excellent teachers and that in terms of learning about cultural safety that “encouraging our clients to become the teachers would be helpful” (CHN4).

Shared decision making also required that CHNs change their perceptions about what success looked like. “Sometimes the medication is just the cherry on the sundae, but the whole sundae is… that we took time together…listened to music… got coffee, or whatever, you know, all those little things” (CHN9). Another CHN described that she was trying to engage a First Nations client on the street and “I can't get him to come to shelter… and nursing practice wise, like, I'm just trying to get him sleeping bags and wound care. But I think he's going to end up in the hospital” (CHN5). They went on to describe that the client had left a supportive housing program because he wanted freedom to be closer to the land. From their perspective, he had struggled with high levels of control in the housing program that was reminiscent of his past and “feeling like he was being controlled all over again” (CHN5). Within programs there may be a fine line between requisite control for a functioning program aimed to support people with substance use and being overly paternalistic and bearing too much resemblance to state interventions that Indigenous Peoples were subjected to in the past (e.g., child welfare programs, residential schools, Indian hospitals, TB sanatoriums).

To summarize this subtheme, relational practices within CHNs individual client encounters, included narrative elicitation, assuming a learner stance, bearing witness to lived experiences, suspending judgment, and shared decision making. These practices were essential to more ethical nursing encounters with Indigenous people experiencing homelessness. CHNs noted that their clients, most of whom have experienced structural violence and harm from HCPs and other service providers within social systems, do not open up and tell nurses what they

actually need, nor do they accept care easily. The above relational practices were essential to cultural safety and other actions to ensure equitable access to care.

Actions For Others

In addition to client encounters, CHNs also described a lot of "behind-the-scenes" or "leg work" that was part of navigating overly complex and problem ridden systems. This behind-the-scenes work was requisite to ensure their clients received appropriate care and were not discriminated against. This work was generally undertaken *for* clients rather than *with* them. Furthermore, CHNs described advocacy efforts on multiple levels, but mostly suggested that they engaged at the individual level, which is the focus of the following section.

Tremendous Amounts of Advocacy. Individual level advocacy was described by one CHN as "really just using my voice to speak up for people and make sure that they're getting the care that is equal to what other people would get" (CHN5). Therefore, advocacy was critical to counter the problem of judgmental attitudes or biases when marginalized clients needed access to acute care or emergency services. Another CHN described how she engaged in advocacy to

> try to quell any judgements and biases that might happen when… that client [needs] to access those services, to communicate first, send letters, give good assessments so the client doesn't have to… repeat and verbalize everything and then fall into a little bit of a trap of judgements. (CHN8)

Ideally, behind-the-scenes work was informed by client's goals and shared decision making and this more invisible work largely fell into the overlapping categories of care coordination, systems navigation and individual level advocacy. Notably, systems navigation and care coordination required a lot of time, being a skilled negotiator and confident about speaking out on behalf of

their clients about what is just or "right" and to ensure appropriate treatment by care providers and adequate access to healthcare to prevent further harm.

CHNs all described that individual level advocacy and systems navigation was the bulk of the work they did. They described that it was more time consuming than they were given credit or funding for, but that it was one of their favorite parts of the job. "Basically, my work here is all advocacy. I advocate the most in terms of the housing crisis" (CHN3) and "sometimes you're so close to it that you don't see it, yeah [advocacy] that's kind of the whole role" (CHN4). One CHN described that when CHNs are new to the role "they'll see it as very excessive the amount of advocacy… and coordination" and went on to describe how they engaged in "tremendous amounts of communication, texting and calling and writing letters… lots of information sharing to decrease that load on the client" (CHN8). CHNs all described similar advocacy and care coordination practices that required considerable time and communication.

Behind-the-Scenes Work. Clients were involved in CHNs' advocacy efforts in the sense that CHNs would ask them what their goals were or what the client wanted to work on or needed help with. However, beyond goal setting and collecting information CHNs described that the bulk of what they did was without the client present and used phrases such as "doing the leg work" or "behind-the-scenes." Advocacy often took the form of lots of phone calls and writing letters for clients to go with them to appointments or to the hospital. Another CHN described that "I've had to go there myself with the person and say this guy has a test. It has to be done. Last time he was here he wasn't treated nicely" (CHN6). Attending appointments with clients is time consuming and may not always be the best use of scarce CHN resources, and it is unfortunate when it needs to come to that level. Arranging a peer support was another common intervention to support clients and help them advocate for themselves in various settings. Arranging peer

support is also more in line with an advocacy *with* rather than *for* approach. Peers must be empowered within organizations to speak out against HCP's discriminatory behaviours, for example, with assertiveness training and conflict negotiation skills.

Advocacy Related to Harm Reduction Care. A number of CHNs expressed concerns about advocating against destabilizing medication changes that were based on stigma rather than evidence. "A lot of times when clients go to the hospital, they change how they give their medication. So the clients don't have ready access to them" (CHN10). This was problematic because CHNs and clients had often worked hard together over prolonged periods to stabilize clients with mental health medications and opiate agonist therapies (OAT). Sometimes getting clients to agree to take any medications regularly required considerable time to build trust over months or even years. Clients were vulnerable to overdose following hospital discharges or after being released from corrections facilities, and this risk may increase when opiates are titrated down during their stay. CHNs described calling to follow-up with hospitals after a client is admitted to advocate against destabilizing and unnecessary medication changes in hospital and/or to ensure that clients on OAT or safer supply received adequate pain management.

Financial Advocacy and SDH. In addition to advocacy towards access to harm reduction care in hospital settings, CHNs also engaged in financial and housing advocacy. For example, CHNs described sending a support person with clients to the bank to ensure that they were served, helping with taxes and access to income supports to address poverty, and getting IDs, so clients would have all the requisite documents and be what some CHNs described as 'doc ready' for housing. One CHN described how important financial advocacy was for their clients.

> For me [advocacy] is finding out every possible thing that I could… set up… if I could get you special diet money for hypertension, we're doing it. Anything I can squeeze out

> of the system to get you extra money or to get you top of the list for something. Anything… I can get my hands on… to give them all the options possible. (CHN2)

Access to SDH, including income supports and housing, are essential for people experiencing homelessness to prevent further declines in health and wellbeing.

Ontario Disability Support Program (ODSP) was one area where knowledge of SDH were applied to practice. CHNs highlighted the importance of submitting ODSP applications as a means to help people in obtaining housing. One CHN described that getting clients onto ODSP was a program goal. “We fought for all of our clients to have at least a basic income… so they can meet survival means… when you have a basic income, at least you can focus on the other areas of your life” (CHN3). Another CHN described how nursing students, and even experienced nurses new to the role, struggled to make the connections between SDH and completing ODSP applications. They described the student interactions in the following way:

> Yeah, this person's here for this infection, but also, they’re on OW [Ontario Works]. Ask them why they're not on ODSP… and they're like ‘well what's the [point]?’ and I'm like ‘it's double the income’... This is actually the most impactful thing you can do for this person's health, right? And this is new information for people… This is actually what drives illness and health in communities. It's poverty… and you have a role to play here. You can actually fix this and sure it doesn't feel like a nursing thing because you're not putting a needle in someone, but it's actually so much more impactful, right? (CHN7)

ODSP applications can be lengthy, and a number of CHNs highlighted that it can be challenging to support clients through the process, for example some application questions were triggering when they had to articulate trauma or elements of their life story, and some clients had difficulty with attention for long periods and low literacy levels. Participants described how the transient

nature of their clients' lives could also be a barrier if they needed to split the process into smaller pieces. However, filling and signing the initial ODSP application is within the scope of practice of Ontario RNs, which is unlike many other applications for disability supports and government funding that require a physician to review and sign the form. Relationships forged by CHNs with their clients may have increased the chances of successfully completing forms with or for clients. All of the above makes completing ODSP applications an important CHN responsibility to work to their full RN scope of practice and address inequities.

***With* Versus *For*, and The Need For Greater Power Sharing.** The notion of advocacy *with* (rather than advocacy *for* clients) generated some deeper reflection among CHNs and many CHNs acknowledged that they had not considered involving clients in their advocacy efforts. "Oh engaging them? Wow, well that's kind of tough because I guess you want them to be able to advocate for themselves… but at the same time, they don't hold a lot of power" (CHN2). Another CHN described that she would try to advocate with the client as much as possible "with the intention of empowerment… if there's support that's needed or skills that's needed or doing a mock run through of the phone call… just literally be alongside to support… yeah not always" (CHN8). CHNs suggested ways they could include clients more such as inviting them to meetings with their care team and just being present while clients made their own phone calls. Speaking on behalf of others with less power was described as tricky and could slip into White benevolence, but at the same time nurses acknowledged that their power and privilege as a White person and as an RN was often what enabled them to advocate and be heard. However, this might mean also being a silent supporter to ensure authentic inclusion rather than tokenism. Participants brought up their White privilege, but then struggled to describe how being White

enabled them to advocate and also struggled to determine when they should use their privilege to speak out and when they should be a silent supporter.

> It can be a real strength for advocacy because I have the privilege of being White and people will maybe take what I say maybe more seriously?... but I think also as the world is changing, getting more aware, there is also that thing of yeah um [long pause] it's just so uncomfortable sometimes, like advocacy can just be so uncomfortable. (CHN5)

Despite acknowledging their privileges, CHNs still felt powerless in many ways. Whether or not CHNs felt they had power in a situation influenced whether they were likely to act, for example by engaging in advocacy or speaking out against injustices.

Shared Humanity and Emotional Motivations for Advocacy. Emotional connections were a significant motivator for CHNs' work in harm reduction and they suggested that they valued the kinds of relationships that were integral to working in community settings, rather than the task-oriented nature of acute care. The notion of shared humanity frequently emerged in interviews, and CHNs expressed a strong desire for people experiencing homelessness to receive better care. They argued that simply being human should be the only thing requisite to receive compassion and care, "working in harm reduction that's supposed to be your approach to working with humans, right? It's like, humans who are oppressed by… bad drug policy, and policy driven poverty and all of these systems… that create suffering" (CHN7). Shared humanity was an emotional and relational motivator for CHNs' individual level advocacy work and some participants passionately claimed that dignity as a human being should be universal.

> I've always just felt… we're all human beings. We all share challenges in life, you know. Some people come from a place in which they've had a lot more trauma or hardship. But in general, it says even in our charter, like, we're all equal, we're all deserving of life,

> liberty, security of person… and knowing that certain people groups are so disadvantaged… my heart yearns for them to get better care. (CHN3)

Shared humanity and relationships motivated CHNs to engage in individual level advocacy for clients, although interestingly, their one-on-one relationships with clients did not seem to motivate higher level advocacy. Organizational level advocacy seemed to be undertaken when CHNs perceived that there was injustice in a particular policy or leadership practice. Importantly, superficial relationships between individuals from radically different social positions may not generate a true sense of shared humanity. Therefore, there is no guarantee that a sense of shared humanity will emerge as a motivator for all nurses to engage in anti-colonial actions.

Beyond, individual level advocacy, CHNs engaged in meso level advocacy for changes within their organizations when institutional and leadership decisions were perceived to cause harm, but that going against the grain within their organizations could be both risky and exhausting. Further they acknowledged that they rarely or never undertook macro level advocacy (e.g., political action, advocacy for policy changes). Additionally, advocacy tended to be *for* clients versus *with* them. Barriers to doing *with* included time and client capacity described in previous chapters. Additionally, CHNs did not feel that their advocacy and systems navigation work was adequately supported in terms of time, funding, and recognition by their community health organizations and other actors that allocate community healthcare funding. Adequate funding is requisite to cultivating and sustaining ethical actions over time.

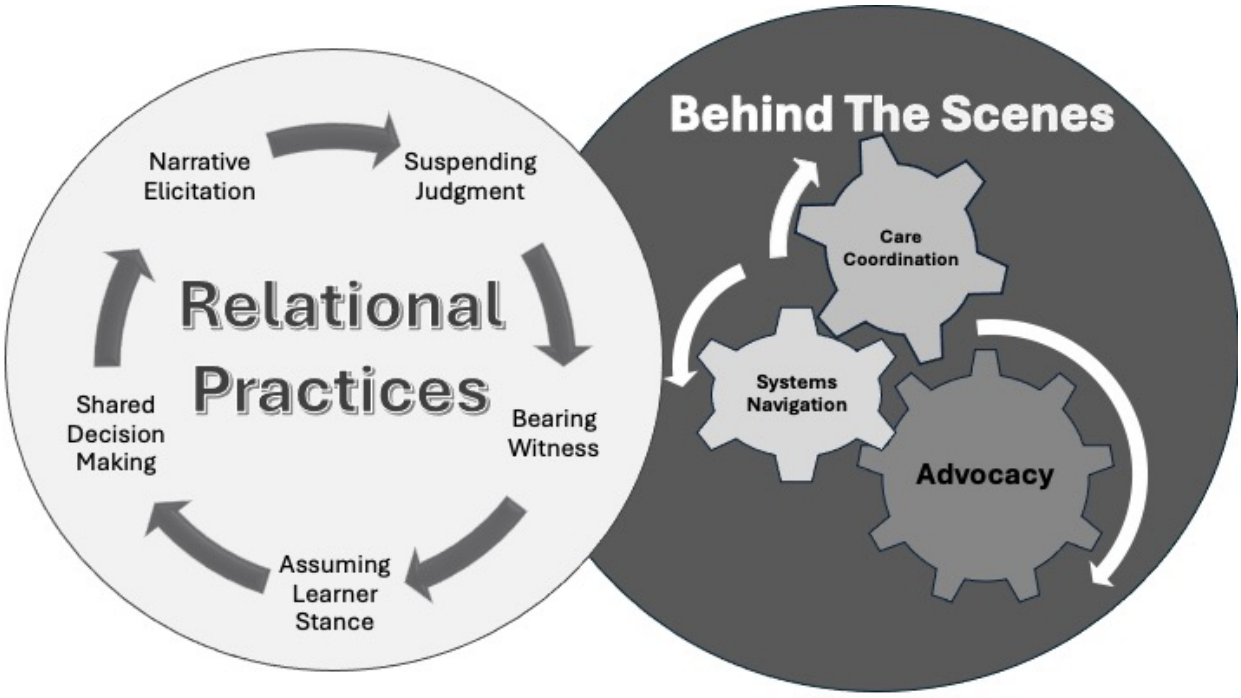
Visualizing Nursing Action and Summary

A detailed image of CHNs anti-oppressive actions emerged from the interviews (see Figure 7.2). Represented by the circle on the left, are actions that CHNs engaged in within their relationships and client encounters. The continuous circle indicates that these actions are

interrelated and ongoing. The circle on the right, which is larger than the left, but partially obscured, represents the "behind-the-scenes" aspects of CHNs work. CHNs also invested considerable time into building relationships and relational practices are also more or less invisible. Care coordination, systems navigation, and advocacy are the inner mechanics of their roles, represented by the turning gears. This circle is slightly larger, not because it is more important than relational practices, but rather because, CHNs noted that behind-the-scenes actions were a large part of their role and they also described the "tremendous" time and energy that they invested to ensure people had equitable access to care.

Figure 7.2

CHNs' Anti-Oppressive Actions: A Visual Summary



Theoretical Implications and Ethical Approaches to Relationships

In the following sections, I return to the literature and my theoretical framework to further expand and analyze the above nursing actions. As I have argued previously, but which I cannot understate—relationships are essential to anti-oppressive nursing practices, which my findings confirmed. Relationships can lead to healing or harm, and they can encourage or discourage access to healthcare (Horrill, 2021; MMIWG, 2019b). Relationships can make people feel safe and supported, or make them feel vulnerable, traumatized, and alone (Benoit et al., 2019; Birrell & Freyd, 2006; Goodman et al., 2017). Relationships can be positive or negative, culturally safe or unsafe (Bucharski et al., 2006; Ramsden, 2002). Relationships are formed through each encounter with another person, and our behaviours (verbal and non-verbal) during the encounter shape how the other person feels about themselves, and about the relationship that they share with you. Furthermore, relational behaviours are dependent on thinking patterns, values, beliefs, and our perceptions of others (Doane & Varcoe, 2007). Subjectivity is at the heart of relationships and interactions between people (Oliver, 2015), which I move to next.

Understanding Subjectivity and Witnessing

I draw on Oliver's (2015) notion of witnessing to understand subjectivity, which I introduced in chapter two. Oliver described subjectivity and our sense of self as being formed in relation to others (i.e., address and response). People also develop an inner witness to whom they address their lives within and to themselves. Subjectivity and one's inner witness can be harmed or destroyed by violent responses from others, and can only be restored in the presence of an addressable other (Felman & Laub, 1992; Oliver, 2004, 2015). Social circumstances, such as homelessness and social isolation may also damage one's inner witness. Oliver (2015) noted that address and response was the structure that made testimony possible. Therefore, she argued that

witnessing was an ethical approach to ensure address-ability and response-ability (a word play that indicated our ability to address and respond with another and our ethical obligations or responsibility to others). Oliver described the productive tension between "*eyewitness* testimony based on firsthand knowledge, on the one hand, and *bearing witness* to something beyond recognition that can't be seen, on the other, [as] the heart of subjectivity" (Oliver, 2015, p. 483).

Bearing witness is critical within many Indigenous cultures for collective remembering within oral traditions and is integral to their systems of law, healing practices, and sharing circles (Ariss, 2021; Koptie, 2010; Simons et al., 2020). Indigenous witnessing ethics informed the TRC and also informed the First Nations Child and Family Caring Society of Canada's "I am a Witness" human rights campaign (Ariss, 2021). Nursing scholar, Madeline Kétéskwēw Dion Stout of the Kehewin First Nation & Tsawwassen First Nation introduced the Cree concept of Nīpawīstimatowin *(bearing witness for one another)* as a key element of nursing relationships with Indigenous Peoples (Bourque Bearskin et al., 2020). Some First Nations communities designate people for the role of witness and have words and theories specific to describe the process of bearing witness (Ariss, 2021). For example, the Stó:lō concept of Xwélalà:m is used to describe listening, but a more fulsome translation is *witness attentiveness*; additionally, the Gitxsan, Carrier, and many Coast Salish Peoples also select individuals to be honored witnesses at feasts and other ceremonies. The role of witness is a deeply ethical endeavor to capture not only details within ones' heart and mind, but also the emotional essence that honors and respects the storytellers. (Ariss, 2021). Moreover, the process of witnessing is clearly connected with narrative elicitation, which is fundamentally about address and response. I explore narrative elicitation and the sharing of stories in depth momentarily, but first I explain how Oliver's theory of witnessing can expand our understandings of CHNs struggles to see racism.

Oliver (2015) problematized theories of recognition as the core of an ethical subjectivity for engaging with others different from ourselves. She argued that relying on recognition as the basis of our ethical approach to otherness was problematic, in part, because of the limits of our cognition. CHNs struggled within themselves to see and acknowledge (i.e., recognize) racism, for example, some CHNs were ambivalent about labeling problems as racism, at times this potential blind spot may have persisted even when they were eyewitness to discrimination, which reflects a theoretically very significant limitation to respond to racism. Arguably, withholding recognition of racism maintains privilege and power among White people (Coulthard, 2007; Fanon, 2007; Oliver, 2015). Therefore, nurses need to struggle towards new ways of being in relation to others, which requires a more radical intersubjectivity than recognition allows. One might expect an inability or unwillingness to recognize racism to impair the ways in which CHNs responded to racism or their approach towards others who might share stories about their own experiences with racism; however, this did not seem to be the case. Importantly, the practice of bearing witness to people's stories, which involved listening without judgment and believing what people had to say about their own lives, were essential to overcome CHNs' inabilities to recognize racism. Therefore, witnessing represents an ethical stance and path forward.

Importance of Narrative Elicitation

Narrative elicitation is an important relational behaviour to build trust, to get to know each other better, to understand another's life story and their social circumstances, and to learn about a person's needs in relation to their health, wellness, and nursing care (Anderson et al., 2003; Blix et al., 2019). Narrative elicitation was also essential to the kinds of behind-the-scenes anti-oppression work that CHNs described. For example, narrative elicitation is essential to advocacy work, because nurses cannot effectively engage in advocacy at any level (individual,

institutional, family, community, population) without first learning about peoples' stories, their social circumstances, and their needs/desires/goals. Similarly, nurses cannot coordinate care and help people navigate systems without knowing their clients. "Narrative elicitation has potential to be democratizing, especially for those that have long been afforded less time and attention than those who are more privileged, powerful and skilled to make their voice heard in clinical communication" (Naldemirci et al., 2021, p. 187). Narrative elicitation is not without risk.

Risks and Benefits. Narrative elicitation has the potential to bring to the surface traumatic experiences and memories. Nurses must be prepared to support people experiencing strong emotions or distress related to the stories they tell. Even stories that begin as reminiscing about positive experiences may provoke a strong sense of grief and loss, given the severed connections to family, home, community, culture, and land that occur in the context of Indigenous homelessness. Importantly, persons that share a similar background as their nurse may be privileged during processes of narrative elicitation (Anderson et al., 2003; Naldemirci et al., 2021). Naldermici et al (2021) conducted observations of nurses' narrative practices and focus groups of nurses' perspectives on narrative elicitation with their patients in acute care. Sharing chemistry and emotional connections were discussed during their focus groups.

> Yet often very vaguely, with care taken not to sound 'discriminatory'… 'personal chemistry' can be seen as a diffuse, even mystifying term for sharing similar life-worlds and expectations, worldviews, cultural norms, maybe even class positions. In other words, nurses arguably individualise similarities in their social imaginaries by labelling these as 'chemistry'… [which] may lead to a credibility excess and greater openness to listen more actively to some stories. (Naldermici et al., 2021, p. 192)

Naldermici et al (2021) found that when nurses felt chemistry with their patients, they were more likely to spend additional time with them; whereas, when chemistry was absent, nurses were more likely to describe feeling 'uneasy' with narrative elicitation or to find it time consuming and burdensome. Therefore, nurses were less likely to hear the stories of people different from themselves, did not develop strong relationships and emotional connections with them, and were less likely to respond to their needs. Naldermici et al (2021) argued that persons most in need of nurses' time and active listening for narrative elicitation were often the least likely to receive it. I suggest that nurses may miss important opportunities for anti-oppressive action when they do not critically reflect on relational elements of advocacy and the ease of developing relationships based on similarities rather than differences. Additionally, narrative elicitation is not about simply eliciting responses during clinical communication, for example, asking people about their health history, or asking them to describe their health-related symptoms and their main concern that motivated them to seek care. CHNs described that sharing stories were essential to their work with Indigenous and non-Indigenous people alike, who were experiencing homelessness.

Narrative Care. Narrative care is an interesting, albeit underdeveloped concept that captured the essence of the kinds of narrative elicitation and sharing stories that CHNs described. Narrative care is not the same as narrative therapy, which is a trauma treatment modality that requires specialized training and dedicated therapy sessions. Narrative care is a promising approach for nursing grounded in relational practices (Randall et al., 2015). Relational ethics complements narrative care and may cultivate safer spaces to build trusting relationships (Blix et al., 2019). To date the concept of narrative care has focused on older adults and dementia in the context of long-term care settings (Baldwin, 2015; Berendonk et al., 2020; Villar & Serrat, 2017). Narrative care has not been explored with CHNs working in harm reduction or with

people experiencing homelessness. In my literature searches for narrative care, I found only a handful of articles and none of them offered a clear and concise definition of narrative care. Therefore, based on my interview findings and analysis of the literature, I offer the following working definition: *Narrative Care is a strength-based approach that recognizes the potential for healing and wellbeing that exists in everyday narrative encounters between nurse and person, it honors people's stories and places relationship building, through telling, listening, and co-constructing stories, at the center of care.* Narrative care "is not just one more task… if there is time; it should underlie each interaction with the people whom we serve, for at base it is about quality of connection more than quantity of time" (Randall, 2016, p. 3).

Narrative care requires a small story approach to co-construct stories and build relationships during every encounter. Small stories are brief and spontaneous stories and informal everyday conversations as opposed to constructing life stories or big stories that are concerned with a linear plot line and narrative coherence (Baldwin, 2006; Berendonk et al., 2020; Berendonk et al., 2017; Blix et al., 2021; Randall, 2016; Villar & Serrat, 2017). CHNs all described the importance of informal conversations, sharing food, and spending time together with people to build rapport and overcome broken trust. CHNs were witness to profound human suffering, they suspended judgment of people's behaviours, and simply believed people when they told them hard stuff. This practice may, as Oliver suggested, help people heal their inner witness and restore more positive self-identities among people experiencing oppression.

Some storytellers are in some way wounded, either by virtue of the way their health condition such as trauma, or mental illness impacts their ability to tell coherent stories, or because of the way that others perceive the stories that they tell. I suggest conceptualizing a person as wounded implies two things. First, wounding implies harm has been inflicted on the

person either by society or by others, including nurses. Therefore, persons are not problematized, because failings are not intrinsically located. Second, wounding implies potential for healing and reorients us toward recovery, wellbeing, and strength. Wounded storytellers may be judged as not having a story worth listening too—they are silenced. Silencing of voice can inflict deep and lasting wounds. Therefore, an important part of narrative care is to be aware of who is silenced and why, and to reflect on nursing transgressions or harmful attitudes and behaviours that may lead to silencing of voice (Berendonk et al., 2020; Villar & Serrat, 2017). Nursing transgressions that do not support narrative care included, failure to engage altogether, judgment or bias, and power over (Kidd & Carel, 2017; Naldemirci et al., 2021; Witham & Haigh, 2018). Nurses that avoid other's experiences of pain and suffering violate nursing ethics. Similarly, "neglecting others' stories or refraining from engaging in narrative co-construction is essentially the avoidance of others' experiences, which is neither ethical nor good" (Blix et al., 2019, p. 1919).

When people are not able to tell their stories or the stories they tell are not heard, they may be "de-storied" or "narratively dispossessed" (Baldwin, 2006; Berendonk et al., 2020; Berendonk et al., 2017; Blix et al., 2021; Randall, 2016; Villar & Serrat, 2017). Identities are constructed through narratives over time and are central to personhood (Witham & Haigh, 2018). Therefore, narrative dispossession may threaten personhood and lead to experiences of dehumanization (Berendonk et al., 2020; Villar & Serrat, 2017). Narratives and the process of narration, as conceptualized within a western paradigm, rests on coherency, consistency, and a linear plot line (Berendonk et al., 2017; Blix et al., 2021). Although dementia was the focus of many narrative care articles (Villar et al., 2019; Witham & Haigh, 2018), trauma also impacts the telling of stories and may result in fractured and fragmented stories that lack consistency, coherency, and comprehensibility (Blix et al., 2019). Forgotten or misremembered events and

characters, and/or an unexpected context may lead people to believe that stories are broken and not worth hearing, or they may not be recognizable as a story at all (Baldwin, 2006; Berendonk et al., 2017). Experiences of suffering may be un-presentable or impossible to narrate to others and therefore, suffering remains embodied (Blix et al., 2019; Witham & Haigh, 2018). Reducing narrative care to "story listening implicitly places responsibility on the person in need of care. Paradoxically, the reasons behind a person's lack of storytelling ability may be linked to that person's need for care" (Blix et al., 2019, p. 123). Unfortunately, people may also become a tainted witness in the recounting of their stories of violence and harm, similar to narrative dispossession. Social positioning influences whether or not the stories we share are believed, and women and racialized people are more likely to become tainted witnesses (Gilmore, 2017).

Story-telling shapes not only our identity but who we are becoming (Blix et al., 2019). Narratives are unstable and can be (re)told with different meanings and future implications ascribed to the same event with each telling and each new listener. Therefore, narrative care maintains an open and ethical space for the narrative future and future becoming (Baldwin, 2015; Blix et al., 2019; Randall et al., 2015; Randall, 2016). Experiences are always in process and stories are never fixed, they evolve over time (Berendonk et al., 2020; Randall et al., 2015; Witham & Haigh, 2018). 'Playful uncertainty' within a narrative care approach allows others to become who they want to be (Blix et al., 2019), which fosters possibilities and hope for the future (Blix et al., 2021; Randall, 2016).

A narrative care approach where the nurse enters into the story world of another also known as 'world traveling' may generate compassion, curiosity, and inclusivity (Baldwin, 2015; Blix et al., 2019; Blix et al., 2021). Traveling into the world of another allows us to see ourselves through their eyes and to reflect on how we are perceived requires humility (Blix et al., 2021).

This attentiveness to understanding another person creates a more ethical relational space. Ethical world traveling requires respect for the fundamental unknowability of the other. Story listening is more than paying attention to words, truly hearing a story requires attention to relationships between how people tell their stories and the circumstances involved in the telling (Blix et al., 2019). Shifting from silencing of voice to promoting agency begins with asking open ended questions, holding time and space for silence, creating an ethical relational place, encouraging small stories, and slowly co-creating counternarratives that promote change (Witham & Haigh, 2018). At the heart of narrative agency are understandings of all the ways in which a storyteller can be wounded and working to redress those harms. Therefore, agency is not about giving voice to others, but rather upholding or restoring personhood, and the right to speak for oneself with power and authority. Stories may also be shared in the process of advocacy, because stories may humanize problems that are the target of advocacy efforts. Therefore, stories are also important in the context of human rights work. Next, I describe some of the ways in which relationships are foundational to nursing advocacy.

The Relational Nature of Advocacy

MacDonald (2007) conducted a systematic review of qualitative literature on nurses' perspectives of enacting advocacy and the elements that influence whether, how, and on whose behalf nurses advocate. Nurse-person relationships were both a motivator for advocacy and potentially strengthened through the process of advocacy. Indeed, most studies that MacDonald (2007) reviewed highlighted that relationships were fundamental to advocacy, and relationships were the primary theme found in her review. Nurses identified that advocacy conveyed a sense of support for the patient, built trust, and "triggered a stronger bond" (MacDonald, 2007, p. 121). Nurses were motivated to make a meaningful connection with their clients based on '*common*

humanity' and empathy. "As a result of this sense of emotional connection with patients, nurses' emotional responses to perceived violations of patients' dignity or rights were a powerful trigger for advocacy" (MacDonald, 2007, p. 121). Additionally, nurses' emotional responses, such as empathy and vicarious suffering of others, and nurses' '*regard for personhood'* motivated them to engage in advocacy (MacDonald, 2007), which is similar to my findings with CHNs.

MacDonald's (2007) review focused primarily on nurses advocating on behalf of individuals and families. Their review did not explore nurses' advocacy with communities, or nurses collectively engaging in political advocacy. Plausibly, previous interactions and emotional responses to situations over time may also motivate nurses to engage in collective political advocacy. However, despite CHNs strong emotional reactions to injustice and suffering, they typically did not engage in political action and higher levels of advocacy. CHNs reported a lack of time and organizational support to engage in collective advocacy and that this form of anti-oppressive action would need to be undertaken outside of work. Other studies suggested that barriers to engage in political advocacy included undervaluing of nurses potential contributions by policy actors and lack of the following among nurses: time, power, knowledge, skills, self-efficacy, leadership support, and opportunities to participate; however, neither barriers nor motivators to engage in political advocacy are well studied (Asuquo et al., 2016; Rasheed et al., 2020; Scott & Scott, 2021; Spenceley et al., 2006). Future research should explore nurses' experiences and motivations to engage in all levels of advocacy and collective advocacy efforts (Chiu et al., 2021; Rasheed et al., 2020; Scott & Scott, 2021; Spenceley et al., 2006).

CHNs reported advocating for changes within their workplace, but this was often not easy, and could require considerable effort and risk when advocating against policies or practices that were implemented and supported by leadership. In Macdonald's (2007) systematic review

on advocacy and Jackson et al.'s (2014) review on whistleblowing in nursing, relationships with other team members within the nurse's workplace and the organizational culture influenced nurses engagement in advocacy and willingness to speak out about practice issues and unsafe care. Particularly, nurses' willingness to advocate depended on whether other team members shared similar values and goals, and whether they worked within an organizational culture that fostered an atmosphere of trust (Jackson et al., 2014; MacDonald, 2007). Brockie et al. (2023) highlighted advocacy efforts of Indigenous nurses "who see broken systems are standing up for their communities to make a difference, in often very hostile environments" in Canada and other settler colonial states such as Australia and New Zealand (p. 617). Regardless of one's cultural background, engaging in advocacy, is not without risk, such as, conflict with others, feeling ostracized by colleagues, and being punished by organizations or superiors for speaking out (Gagnon & Perron, 2020b; Jackson et al., 2014; Sellin, 1995). Nurses require conflict resolution skills to successfully navigate these potential risks (Jackson et al., 2014; MacDonald, 2007). Indigenous nurses in particular require recognition, pay equity, and leadership opportunities to further their advocacy efforts (Brockie et al., 2023). Nurses must stand in solidarity together against racism despite the risk of hostility from others.

The relational nature of advocacy at both the nurse-person and organizational levels suggests a need for relational ethics and vigilance around when one feels compelled to advocate, and most importantly critical reflection about when and why, one does not advocate for others despite a need to do so. Sellin (1995) found in their qualitative study of advocacy that

> A few nurses reported having a difficult time taking any risks of advocacy for people who were socially compromised in some way… [with] the social stigma attached to these patients. This made caring about them even more difficult than caring for them, and the

> thought of advocating for them became a remote idea. Thus, whether or not a nurse was willing to take a risk and expend the effort to advocate for a patient depended somewhat on how the nurse felt about the patient as a person. (Sellin, 1995, p. 27)

This finding supports the importance of building skills in narrative elicitation and intentionally developing trusting relationships with all clients. MacDonald's (2007) review did not raise concerns with relationships, emotional connections and emotional responses to others as being primary motivators for nurses' advocacy. However, I argue that those persons most in need of advocacy may be least likely to form emotional bonds with nurses due to factors such as trauma, mistrust, stigma, discrimination, cultural differences, and language barriers. CHNs described that shared humanity was a motivator for their work, but importantly they chose to primarily work with marginalized peoples and cared deeply about them. Furthermore, as Sellin (1995) described the *humanity* and *personhood* of those on the margins of society (e.g., persons living with mental illness, substance use, and homelessness) may be held in disregard by many people including nurses. This calls into question whether notions of *common humanity* and *regard for personhood* identified by Macdonald (2007) as motivators for advocacy are universally applied to everyone that nurses encounter in their care. Many nurses may not feel a shared sense of humanity with others perceived as different, inferior, or in some way responsible for their social position.

Furthermore, when we connect Naldermici et al's (2021) findings about nurses' discomfort with narrative elicitation across cultural, language, and socioeconomic differences with Macdonald's (2007) findings that emotional connections are a primary motivator for nurses to advocate, we can see that nurses may be less likely to advocate for persons that are from backgrounds different from themselves. Relational ethics demands that nurses bear witness to stories and advocate for others regardless, or perhaps especially when, narrative elicitation is

difficult and emotional connections are absent (Blix et al., 2019). Additionally, nurses must understand that advocacy is a relational practice motivated and strengthened by emotional connections. Nurses may miss important opportunities for anti-oppressive actions when they do not critically reflect on the ease of developing relationships with others based on similarities rather than differences (Anderson et al., 2003; Blix et al., 2019; Sellin, 1995). Perhaps, one of the most important shifts for CHNs to consider, is how to engage people in their own advocacy. CHNs highlighted that most of their advocacy was at the individual level, but that it was also advocacy *for* their clients on their behalf rather than advocacy *with* their clients and broader communities. In addition to relational ethics, healing centered engagement may be a useful framework to shift nursing care towards a focus on strength-based and community-centered care.

Healing Potential of Community Engagement in Advocacy. Ginwright (2018) a Black educator and scholar proposed the concept of healing centered engagement to shift from a singular focus on trauma towards healing through relationships, community engagement, and political action. He was critical of trauma informed care, because, although it is intended to be strength-based, a focus on trauma can problematically, and often very quickly does, become deficit-based. Moreover, a singular focus on trauma may be a barrier to doing advocacy *with* rather than *for* vulnerable communities. Ginwright's (2018) framework was based on theoretical foundations of critical pedagogy and informed by his work as an educator with marginalized Black youth living in inner-city neighborhoods in the US. Four key elements of Ginwright's healing centered engagement included: 1) it is explicitly political, 2) it is culturally grounded and views healing as the restoration of identity, 3) it is asset driven and focuses on the well-being we want, rather than symptoms we want to suppress, and 4) it supports service providers with their own healing (Ginwright, 2018). Ginwright (2016) previously found that community engagement

in political action held healing potential among marginalized youth and that it also helped to restore their positive identities and sense of agency.

Nursing care aims to support healing and well-being in order to improve overall health. Unfortunately, current health systems focus on providing individual level interventions and trying to change behaviours among individual people to improve the overall health status of populations (Varcoe, Browne & Cender, 2014). However, this approach is typically ineffective when working with people who are oppressed by systems and structures because behaviours and healthy choices are enabled/constrained by social circumstances and people's social position in society. Additionally, a focus on individual level interventions, does not capitalize on community strengths (Chandler & Lalonde, 2008). Ginwright (2016) is adamant that transforming trauma requires hope for a better future and that social change originates in the heart when people declare '*an unapologetic radical love'* for others in their communities. A better future for Indigenous Peoples can be achieved, but requires political action against human rights violations and systemic oppressions that causes trauma and a sense of hopelessness in the first place (Kirmayer et al., 2003). Furthermore, restoring hope requires immediate action towards healing past harms and achieving health equity (Ginwright, 2016; Kirmayer et al., 2003).

Importantly, nurses must expand their knowledge of politics to engage in policy work, advocacy, and political action, just as approaching health equity and oppression as ethical issues requires nurses to expand their understandings of ethics. Ideally ethics informs politics such that politics are enacted ethically, but this is not always the case. According to Oliver, politics dwells at the level of the universal with general principles and universal laws for the common good. Ethics naturally dwells at the level of the singularity of each being and the unique relations and circumstances of the individual. Although some people may attempt to universalize ethics, it

becomes virtually impossible for people to apply a universal approach in practice. Therefore, justice sits at the uneasy juncture of ethics and politics—consideration of universal laws and unique circumstances (Oliver, 2015). Oliver suggested that political recognition does not ensure that politics are also ethical, nor does intellectual recognition ensure that justice will be served. "The question for politics today is how to bring the ethical concerns for the singularity of each living being into politics" (Oliver, 2015, p. 475). At the point of care, nurses have limited power to confer political recognition on others; however, CHNs are well positioned to articulate ethical concerns related to the unique peoples that they serve. The challenge for CHNs is to respond to an ethical call to advocate for and with people experiencing homelessness and to bring their concerns into politics through the collective advocacy of their healthcare institutions.

Embodied Vision and Radical Relationality

CHNs struggled to *recognize* racism. Arguably, the invisible lens of colonialism influenced their ability to *see* and understand racism. Moreover, Oliver suggested that although recognition may be required in political and legal realms "to change public policies, the ethical foundation of this politics must always take us beyond recognition, beyond *seeing as*, to a realm where our confidence as seers or knowers is shaken to its foundations" (Oliver, 2015, p. 486). The politics of truth and reconciliation are made palatable to settler colonialist worldviews, through the whitestream notion of promoting diversity and inclusion *within* existing institutional and political systems; therefore, the radical, emancipatory, and dialogic praxis required to achieve systemic transformation, decolonization, and health equity may be lost. I argue that shaking the foundations of seeing and knowing are required as part of a radical praxis to instigate anti-colonial actions among settler nurses and to transform oppressive policies. Therefore, how we conceptualize seeing and knowing is critical to anti-colonial struggles.

Recognition is associated with particular notions of vision, which disembody and distance the knower resulting in an objectifying gaze (Oliver, 2001). These notions of vision are also prized in Western science and philosophy as a source of objectivity, unbiased ways of knowing, and ethical judgments. Feminists have critiqued this 'Gods eye view' or the 'gaze from nowhere' as being bound up with Whiteness and masculinity, such that the White male is permitted to claim a disembodied, rational objectivity (Haraway, 1988). Meanwhile, everyone else are defined by their bodies, indeed are "not allowed *not* to have a body" and cannot lay claim to these supposedly unbiased ways of seeing and knowing (Haraway, 1988, p. 575). As feminists have made abundantly clear—objectivity is impossible. Haraway argued, while we should still strive for objectivity in science, we must accept the impossibility of ever achieving it. We must accept that vision is embodied, perspectives are always partial, and knowing is situated in a particular time, place, and relational social space (Haraway, 1988). Nobody (White men included) can make assertions that they can achieve unbiased objectivity. Objectivity presumes maintaining distance between the would-be knower and what can be known. Notions of vision bound up with recognition and an objective (objectifying) gaze presume an empty space, a great divide of nothingness between the seer and the seen (Oliver, 2001). Thus vision and recognition may be considered by some to be alienating and hostile such as Sartre's 'look' in his 1943, *Being and Nothingness* (Anderson, 2021).

Various senses are assumed to be discrete and vision is privileged above all others as foundational to both scientific and ethical objectivity alike. Vision is also part of recognition (e.g., eyewitnesses, seeing is believing, or recognizing a face versus recognizing a voice to identify a person). *I see* or in other words *I know* (i.e., envision equals cognitive thought), but the eyes are part of the body and also part of a complex sensory system, which includes hearing,

touch, smell, proprioception, etc. (Stoffregen et al., 2017). Emotional sensations felt within the body, which are not reducible to rational cognition, are also part of our sensory systems and inform intuitions and insight. Psychologist J. Gibson's work on perceptual systems were groundbreaking in the 1960s. Gibson emphasized the influence of sociocultural environment in perceptual systems (Heft, 2017). In other words, vision does not operate independently of our other senses, vision is embodied, knowledge is situated within the body and its environment, and perspectives are partial and inherently biased. Knowing cannot be based on vision alone because senses work together. Moreover, people are not separated by empty space. The space between us is full with air and various forms of energy that sustains us and connect us to the environment around us and to time and place (Oliver, 2001).

Oliver (2001) argued for a more radical understanding of vision based on light, air, and different forms of energy, including relational (social or affective) energies. Seeing is connected to our eyes, minds, other senses, and to our bodies, but also to light and other particles between our eyes and an object in the distance. It is generally accepted as scientific fact that seeing images depends on light reflecting off objects and entering our eyes. It is also known that many of our senses relate to energy, for example, light, sound, heat, and electrical impulses through our nervous systems. Indeed, we now know that humans even emit low levels of light, albeit so weakly that it's very hard to detect, and this light intensity varies with emotional states and meditation (Zapata et al., 2021). Anecdotally, many people would agree that they can feel energy amongst people, for example the emotional energy in a room at a tense meeting, palpable excitement at large social gatherings, or 'chemistry' between two people; however, there is currently no means of measuring or detecting such relational energy using a scientific device. The phenomena of affective and social energies are controversial and currently lacks scientific

evidence. Oliver argued that similar to the circulation of other forms of energy that sustain life, affective energy "also surrounds us, connects us, and moves through us to sustain us. All relationships… are the result of the flow and circulation of affective energy" (2001, p. 195). The idea that relational energy might impact ways of knowing the world is thus a more radical notion.

Importantly, within most Indigenous paradigms, such relational ways of seeing, knowing, and being ethical within and to the world around us would not be considered radical at all. Relationality has been part of many Indigenous knowledges from time immemorial and certainly precede the work of Oliver and Gibson. I conclude with a quote by Cree scholar Shawn Wilson in which he described deeply relational ways of thinking and connections between mind, body, and spirit similar to Oliver's relational and affective energy described above.

> As we relate this world into being, many other knots and connections are formed that do not take on a physical form. After all, my physical body can be defined by a boundary – generally speaking, my skin – that separates what is me from what is not. We all know though that our emotional and mental boundaries do not necessarily coincide with the physical… Who knows where our spiritual boundaries are; is our spiritual self that infinitely small point of light, or is it the aura that surrounds us and interacts with our environment? Perhaps that point of light is like some kind of reverse black hole – not really a point at all, but a space where so many relationships come together that they emit a light of their own. (Wilson, 2008, p. 76)

I argue that relational ethics are essential to create safer spaces where multiple worldviews meet and interact such as in nursing research, education, and clinical practice. Relational practices and advocacy are essential practices for CHNs struggles against colonialism and oppression. These struggles require us to consider how our ability to *see* racism, the ways that we *see* Indigenous

Peoples and their cultures, and our *vision* in general, is bound up with settler colonialism and Whiteness. Ethical nursing relationships with Indigenous persons, families, and communities and restoring Indigenous wellbeing through political action requires nurses to engage with (not appropriate) Indigenous ways of knowing and Indigenous relational ethics.

In conclusion, healing centered engagement and narrative care are underdeveloped theoretical concepts that may be ideal to guide conceptualizations of nursing advocacy and relational healing efforts in partnership with marginalized communities. Furthermore, I believe that Indigenous relational ethics and perspectives of health and healing have potential to expand the concept of healing centered engagement for nursing practice and education. Healing centered engagement, narrative care, and the healing potential of bearing witness and witnessing ethics are all important areas for potential research and work in the future with Indigenous and other marginalized communities including those that are experiencing homelessness and substance use. CHNs assumed a learner stance and their awareness and understandings of colonialism, trauma, and structural violence enabled the relational practices described above, which supports the importance of ongoing nursing education in these areas.

In this chapter, I identified an emerging framework of anti-oppressive nursing actions. Relational practices included narrative elicitation, bearing witness, suspending judgement, assuming a learner stance, and shared decision making. Additionally, I explored and brought to the fore CHNs behind-the-scenes work including advocacy, systems navigation and care coordination. I argue that the more invisible work of nursing must be brought into view for leadership recognition and funding support. The practice of bearing witness and suspending judgment has the potential to provide positive feedback loops because these practices can improve nurses' awareness of how systemic racism and colonialism impacted people's lived

experiences. Therefore, the practice of bearing witness is beneficial to not only the client, but also the nurse when it is used in conjunction with critical reflexivity, self-guided reading, and opportunities to debrief and assist ongoing learning in safe supportive environments. Responses from others in relation to CHNs actions may in turn influence their own beliefs, for example about their own efficacy to make changes and to identify areas of improvement for client care. All of the above makes Oliver's Witnessing Ethics, essential for anti-oppressive nursing practices. The next and final chapter summarizes my dissertation and study findings and presents nursing implications and final concluding remarks.

Chapter Eight: Pathways Forwards—Nursing Implications and Conclusions

There will come a time when racist ideas will no longer obstruct us from seeing the complete and utter abnormality of racial disparities. There will come a time when we will love humanity, when we will gain the courage to fight for an equitable society for our beloved humanity, knowing intelligently, that when we fight for humanity, we are fighting for ourselves. There will come a time. Maybe, just maybe, that time is now.

Ibram X. Kendi – Black scholar and critical race theorist (2016, p. 511)

The problem of racism in nursing is immense, but the importance of addressing it is undeniable. As Collier-Sewell (2023) highlighted the need for research on racism in nursing is a given and should require no justification in and of itself. However, it is how we go about this research, and the questions that we ask, that require justification and the utmost of care. I described in the introductory chapter, considerable research that collects and (re)presents racialized nurses' and patients' vast experiences of racism and discrimination in healthcare (Collier-Sewell, 2023; Horrill et al., 2019). Violence and harm inflicted on Indigenous Peoples are also well documented, both qualitatively in the form of horrific stories of trauma, violence, and genocide, and quantitatively through statistics that demonstrate inequities on virtually every indicator of SDH and health outcomes (Allan & Smylie, 2015; Benoit et al., 2019; Browne, 2017; Government of British Columbia, 2020; Phillips-Beck et al., 2020; RCAP, 1996; Troian, 2016; TRC, 2015; Viens, 2019). This research is not new. Yet, the problem of racism in nursing remains, and so we must question whether more research that describes traumatic experiences of racism and violence against Indigenous Peoples will lead to meaningful change.

If people have not been convinced of the extent and consequences of racism by now, it is unlikely that more academic re-presentations of first-hand accounts and staggering statistics are going to change the hearts and minds of those resistant to change (Tuck & Yang, 2014). I did not offer up traumatic stories about anti-Indigenous racism and homelessness to justify my research,

nor did I procure any new research stories of this kind. As Tuck and Yang (2014) critically note this "theory of change puts too much faith in the power of exposure and awareness, and doesn't account for the complacency of voyeurism" (p. 817). Nurses urgently must move conversations forwards from describing the problem of racism and questioning whether it exists, towards meaningful and effective actions towards change. As Kendi implored—The time is now.

My research intentionally turned away from the approach of using stories of harm as a motivator for change. Instead, I looked to explore how situational elements influenced nursing practices, and how anti-colonialism can be cultivated among nurses to enable intentional and sustained action. Therefore, my research exploring nurses' struggles against anti-Indigenous racism, homelessness, and other oppressions provides a unique contribution to the nursing discipline. I hope to move conversations forward in nursing research and practice. In this final chapter of my dissertation, I present a summary of my chapters and the need for a paradigm shift towards relational ethics. I then discuss implications of my findings for nursing practice, research, education, and policy. Lastly, I acknowledge some of the limitations of my study and conclude with reflections on struggles within myself and my learning towards understanding anti-Indigenous racisms and settler colonialism in Canada.

Overview of Dissertation

Throughout this dissertation, I have attempted to foster greater understandings of oppressions facing Indigenous people experiencing homelessness and anti-Indigenous racism in healthcare. Through, in-depth qualitative interviews, I explored anti-colonial struggles among CHNs towards ameliorating these problems. Leadership emerged as key (dis)enablers of CHNs actions within their organizations. Internal struggles to see racism and overcome silence were also barriers to action that are problematically bound up with Whiteness. During the proposal

stage of my project, I considered three main sites for nursing actions (individual encounters, advocacy at multiple levels, and collective political actions), and I suggested that relational ethics should guide nurses' work at all levels. Building relationships emerged as central to CHNs actions. I suggest that CHNs' considerable skill in relational practices offers a strong foundation to support community healing and collective actions. Relationships forged at the individual level form the network for healthy communities and are foundations of politics and ethics at a collective level. I explored CHNs anti-oppressive nursing actions from many different angles and approaches. My research found that CHNs undertook anti-oppressive actions at the individual and organizational levels; meanwhile, systems level advocacy and collective political actions were largely absent. Additionally, most advocacy was undertaken *for* people on their behalf, rather than together *with* them. Political action, policy work, and structural changes are essential to ending Indigenous homelessness; therefore, we must theoretically imagine possibilities to engage *with* communities and support nursing actions at the level of systems. Indigenous and feminist strands of relational ethics may support us to stretch our imaginations to envision a more ethical and just future. Pathways forwards is the focus of this final chapter. I will begin by looking back and summarizing my chapters and findings.

Chapter Summaries

Chapter One. I began my thesis in chapter one with an overview of the problem of Indigenous homelessness and the ways in which it intersects with community health and harm reduction nursing. I discussed many gaps within the literature and positioned my research within these gaps. I found that extant nursing research has focused on BIPOC nurses' experiences of racism within their workplaces. Alternately, research from a variety of disciplines has focused on describing problems of anti-Indigenous racism in healthcare, and exposing problematic actions

among HCPs from the patient/client perspective. Although, there is considerable research that identified how individual nurses perpetuated racism through overt acts (e.g., hurtful comments and behaviours), the ways in which nurses maintain systemic racism are more covert and difficult to study. The patient/client perspective is unlikely to capture the multitude of ways that nurses both maintain and challenge settler colonialism and systemic racism. All of the above research is essential to uncover difficult truths. However, nurses must take action within their own social worlds towards eliminating racial disparities and health inequities. How to take action is understudied, and thus poorly understood. We must explore what motivates nurses to act, and how to enable more positive and sustained action through dismantling barriers to action. I sought to address these gaps with my research question: How do situational elements influence CHN's engagement with anti-colonial struggles within themselves, within their social worlds, and more broadly within the socio-political arenas of healthcare and urban homelessness in Ontario? A better understanding of nurses' anti-racist actions, and the ways in which they perpetuate, maintain, or challenge systemic racism and settler colonialism, is requisite to move forwards.

Chapter Two. Chapter two described my research methodologies and theoretical underpinnings. My study was firmly situated within a critical paradigm. Feminist and Indigenous strands of relational ethics were the main components of my theoretical framework. SA, which has critical theoretical roots, was my chosen method and I aptly demonstrated throughout this dissertation that it was a good fit for this research study. A thematic analysis of qualitative interviews could not capture the complexity of the situation where CHNs actions occurred. The relational ecological and reflexive approach that I undertook in this study was requisite to begin to understand the problem. CRT, anti-colonial, and critical Indigenous theories also informed my study and theoretical lens. Oliver's (2001) theory of witnessing ethics explored relational

intersections between ethics and politics relative to multiculturalism and racism. Oliver's theory is explicitly feminist, and incorporates a relational approach to ethics, but it is not specific to healthcare. Critical feminist theories, Oliver's witnessing ethics and Indigenous relational ethics informed my analysis of CHNs actions and drew my attention to important relational practices.

Oliver proposed witnessing as an ethical point of departure from that of other theorists' (e.g., Honneth) more Hegelian focus on the struggle for mutual recognition (Oliver, 2015). She attempted to bring subjectivity, agency, positionality, and ethical relationships together in her theory of witnessing (Oliver, 2001). Oliver articulated limitations of recognition for addressing oppression and I took up her arguments in detail in this dissertation. Importantly, she criticized Hegelian notions of recognition as necessarily grounded in an antagonistic struggle or hostile conflict, which makes it difficult to imagine compassionate and ethical relations (Oliver, 2001, 2015). Oliver's theory of subjectivity accounts for social and political positionality of subjects, examines relational power differentials, and attempts to open up the possibility of ethical relationships with the 'other' (Oliver, 2000, 2015). Her theory explores intersubjectivity across differently situated subject positions in relation to racism, which is essential for understanding Indigenous oppression, settler colonialism, and relational power differences in the nurse-person relationship. Theories of subjectivity are important to turn towards in nursing theory, in order to begin to unpack relational healing and harm within individual encounters. Trusting relationships among individuals are the essential building blocks of strong community networks requisite for taking collective actions against multiple intersecting oppressions and homelessness.

Chapter Three. Chapter three focused on broader situations of Indigenous homelessness and anti-Indigenous racism in Canada. I tacked back and forth between my analysis of various situational elements, including settler colonial worldviews, historical elements, social processes

of systemic racism, and White supremacy, and I related these elements to my examination of circulating discourses about homelessness and harm reduction in the media. This chapter was critical to glean better understandings of the kinds of processes and discourses surrounding CHNs social worlds and the kinds of elements that may influence their beliefs and behaviours. I also illustrated the various intersecting oppressions that CHNs were struggling against in their daily nursing practices. Anti-colonialism addresses multiple forms of oppression. Importantly, research exploring nursing's roles in colonialism is critical to uncover difficult truths about nursing history and the ways in which contemporary racism and violence has continuities with historical nursing harms.

Chapter Four. I began this chapter with a broad look at CHNs social worlds and arenas and I provided a relational ecological overview of the situation. I described findings related to my interview sample and their demographic characteristics. I mapped out the situational elements and circulating discourses using SA maps, including a social worlds and arenas map (Figure 4.1), situational elements map (Figure 4.2), and positional map (Figure 4.3). CHNs discursively constructed the problem of Indigenous homelessness. My positional map (Figure 4.3) illustrated some of the tensions between constructing the problem within history and intergenerational trauma as the principal pathway into homelessness, versus recognizing current policies, systems and structures as problematically racist. I explored some of the key issues identified by CHNs including inequitable access to care at their organizations. Finally, I described the conceptual confusion that set the stage for the next two chapters.

Chapter Five. This chapter focused on the TRC Calls to Action #23 and #24 that call for mandatory cultural competency training for nurses. I reviewed nursing websites and regulatory colleges to look for evidence of implementation of these calls. I also presented interview findings

of CHNs perspectives on cultural competency/cultural safety, and their knowledge gaps and training needs. The breadth of issues facing nursing with regards to racism and the many injustices committed against Indigenous Peoples in Canada are overwhelming. Unfortunately, my website review found anti-oppressive approaches to address these issues are underdeveloped as formal practice standards for nursing in Canada. Nursing research has examined oppression using critical social theories such as intersectionality, critical race, feminist, and post-colonial theories. However, to date these theories were not explicitly incorporated into anti-oppressive approaches within entry to practice standards, or as continuing education requirements by the majority of provincial nursing regulatory colleges. Cultural competency, safety, and humility are theoretical frameworks currently underpinning key practice documents that address health inequities on the nursing websites that I reviewed. Critical anti-oppressive approaches must be adopted within nursing education, practice standards, and ethical codes if nursing is to ever move beyond essentialized notions of culture and expose oppressions that are rooted in settler colonialism and White supremacy as principal causes of health inequities.

My findings revealed that most regulatory colleges have not taken steps to provide mandatory education nor develop and *mandate* practice standards and policies specifically to address anti-Indigenous and other forms of racism and oppression. Importantly, individual nurses may not engage in anti-oppression training without a push, which makes regulatory colleges an essential actor to move towards truth and reconciliation in nursing. Collectively, White nurses must work harder to foster a culture that supports anti-oppression work and that holds each other accountable to take action to ameliorate colonial harms. Ongoing practice requirements and education should be included as part of annual registration renewals. Unfortunately, critical anti-oppression frameworks are underdeveloped and underutilized in formal ELCs, nursing practice

standards and ethical codes, which must urgently be rectified if nursing, as a discipline and profession, is to meet our obligations to the TRC. Overcoming resistance to anti-oppression training, and in particular approaches informed by anti-colonial and CRT, may be one of the biggest issues facing the nursing profession (Valderama-Wallace & Apesoa-Varano, 2020).

Chapter Six. This chapter situated nursing's lack of progress towards truth and reconciliation within the overall lack of progress in Canada more generally. I provided a broad overview of some of the legal and regulatory elements that should guide nursing action including UNDRIP and human rights. I explored these frameworks in relation to nursing codes of ethics/conduct at the provincial, national, and international levels. I also explored progress on the TRC Calls to Action within CHNs' organizations. Leadership emerged in the interviews as one of the most important (dis)enablers to higher level advocacy efforts and progress on truth and reconciliation within organizations more generally. Institutional (meso) and systems (macro) level advocacy efforts were less common among CHNs and were unsupported in terms of allocation of CHNs' time and funding. Overall, CHNs described that their external situations were not conducive to systems level advocacy or political action. Situational barriers included a lack of time, organizational support, training or skills, and strategic direction. Therefore, this higher-level advocacy was perceived to be going above and beyond their role as CHNs.

When CHNs did involve themselves in meso level advocacy these actions were typically in response to institutional and leadership issues that CHNs felt particularly strongly about, or a perceived injustice. This was described as exhausting to go against the institutional cultural grain and disrupt practices or policies that were encouraged or formally mandated by management and leadership. Political actions were not routinely undertaken by CHNs in this study. Most CHNs either did not know how to become more involved, how to approach this type of anti-oppressive

work, or did not have the capacity outside of work and/or they did not feel that their personality was conducive to the nature of political action. I argue that individual encounters are a potential site for nurses' anti-colonial struggles and are requisite to initiate additional anti-oppressive actions such as advocacy at institutional and systemic levels.

Advocacy is a key nursing role and nurses' individual and collective advocacy for the elimination of social inequities is a central tenant of the CNA's (2017) Code of Ethics. CNA's (2017) Code of Ethics was adopted by most provincial regulatory colleges, except CNO, and calls for nurses to engage in social justice. Social justice has value as a guiding concept for health equity in policy and advocacy work, nursing ethics, and nursing curriculum. The nursing profession must continue to uphold the value of social justice and use this as a lens through which to understand health inequities. Beyond understanding, nursing must resist the tendency to depoliticize social justice aims. Additionally, nurses require guidance on how to enact political advocacy work. Nurses and their respective organizations must collectively advocate for healthy public policy, such as housing first initiatives, harm reduction, culturally meaningful programs ran, with, by, and for Indigenous Peoples that support healing (e.g., land-based programs), and implore settler Canadians to address climate change and environmental destruction that will only exacerbate Indigenous homelessness in the future (Bourque Bearskin, 2014; Kirmayer et al., 2003; Thistle & Smylie, 2020). Relational ethics and UNDRIP should be reflected in any future iterations of nursing codes at provincial, national, and international levels. I argue that critical approaches to relational ethics, human rights, and community engagement are the essence of reconciliation and should form the basis of an anti-oppression framework for nursing.

Chapter Seven. In chapter seven, I tacked back to the niche of the individual nurse and their actions. Importantly, overtly racist comments and racially coded yet stigmatizing language

were not present among CHNs in the interviews. Problematic White racial behaviours among CHNs were more subtle, such as difficulty seeing racism, problems overcoming silence, and slippage into color-blind racisms and White benevolence. At the outset, I suggested that there are three interconnected and fundamentally relational sites for anti-oppressive actions. The first site was within individual encounters, the next site was nursing advocacy at multiple levels, and the third site was political action, including political advocacy, policy work, and more radical disruptive actions such as protests or unsanctioned actions, which CHNs rarely undertook.

Within their individual encounters, CHNs nourished client relationships over a long period of time (months or even years) with frequent check-ins because of the difficulty of building trust. Trust was difficult to build and easy to break. CHNs shared stories and spent time with their clients to build rapport (narrative elicitation). Becoming the learner was necessary to experience relational benefits such as learning about Indigenous cultures. CHNs suggested bearing witness was critical to build strong bonds. Bearing witness included validating people's feelings and believing them when they shared difficult stories and experiences. Bearing witness also meant being physically present for their clients during times when discrimination or harm was more likely to occur. Suspending judgment was requisite to both bearing witness and shared decision making. Shared decision-making meant respecting client decisions, suspending judgement of behaviours rooted in trauma, and positioning the client as expert in their own care, which allowed for the provision of care that actually met the client's needs, rather than simply imposing goals of care on the client. CHNs assumed a learner stance to engage from a genuine place and shift power imbalances.

CHNs also described a lot of "behind-the-scenes" work to navigate systems and ensure their clients received care. This work was largely invisible to their clients, because CHNs

generally undertook this work *for* clients, rather than *with* them present. CHNs undertook tremendous amounts of advocacy to ensure individual clients had equitable access to care and were not discriminated against. Finally, I positioned my findings in extant literature and focused my discussions around two interrelated concepts of narrative care and healing centered engagement. I argue that both of these concepts are essential anti-oppressive practices for nurses that should be developed further *with* others including within harm reduction and homeless communities. Additionally, I believe these concepts may be valuable for nursing with Indigenous communities. However, I will let Indigenous people make the determination for themselves as to the value and congruence of these concepts and *lead* an Indigenous specific approach if they so choose.

(re)Imaging Ethical Futures Grounded in Relationality

In developing this research project, it was apparent the proliferation of theoretical concepts and frameworks to choose from in nursing, which were all relevant to the problem of Indigenous homelessness and the provision of community nursing care. Many of these frameworks (e.g., cultural safety, cultural competency, TIC, patient-centered care) are directed at individual encounters between nurse and client and are intended to improve client experiences and/or minimize trauma and harm. Alternatively, there are also nursing frameworks that revolve around health equity (e.g., social justice, equity-oriented care, SDH) that are typically applied at the population or community level. In academia all of the concepts mentioned above are typically explored in isolation as scholars and researchers zero in on a single concept at either an individual, community, or population level. However, nurses as clinicians seem to be expected to apply these concepts and theories to their overall nursing practices, often simultaneously within a single client encounter. Therefore, the framework of my study was not based solely on one concept. I applied multiple intersecting lenses (e.g., race, culture, colonialism) to explore

oppressions, formulate my interview questions and within my approach to data analysis. Despite this important exploration of multiple concepts, my principal framework for my research was relational ethics and I return to this framework now.

Relational Ethics—A Paradigm Shift

I chose a relational ethics framework based on a number of theoretical and philosophical assumptions. First, relationships are fundamental to the provision of nursing care. Ethical relationships must go beyond recognition of cultural differences and move towards healing and human flourishing, which requires openness and ethical responsibilities for others regardless of differences. Second, change starts with relationships. Radical systemic changes requisite to addressing Indigenous homelessness and health inequities will not occur without critically rethinking settler relationships to Indigenous Peoples and their lands. Therefore, reconciliation rests on building ethical relationships and repairing relational harms between settler Canadians and Indigenous Peoples. Third, ethical relationships are fundamental not only to the nurse-person relationship but are also requisite to systemic and structural changes that will come through community engagement and advocacy work. This makes relational ethics a crucial framework through which to approach political action targeting health inequities. Finally, health equity, oppression, and discrimination are ethical issues that demand nursing action. Land back and restoring Indigenous sovereignty are key elements of reconciliation to eliminate disparities in the SDH between settler Canadians and Indigenous Peoples. These issues require a paradigm shift in healthcare ethics from traditional approaches that are founded on notions of universalism, objectivity, and individualism, to relational ethics firmly situated within a critical paradigm.

When we label racism, discrimination, human rights violations, structural violence, systemic oppression, and health inequities as unethical we necessarily need to consider whether

current approaches to healthcare ethics are adequate to address the potential for healing or harm within broader situations beyond the level of individual encounters between nurses and patients (Pauly et al., 2021; Sherwin & Stockdale, 2017; Woods, 2012). Relational ethics is a significant paradigm shift from traditional healthcare ethics or clinical bioethics (Baylis et al., 2008; Bergum & Dossetor, 2005; Jennings, 2019; Kenny et al., 2010). Some commonalities under the umbrella of critical feminist approaches to relational ethics include relational personhood, power, equity, vulnerability, solidarity, and community (Baylis et al., 2008; Gadow, 1999; Hess, 2001; Hodgetts et al., 2021; Jennings, 2018; Kenny et al., 2010; Sherwin & Stockdale, 2017; Woods, 2012). Many of these same commonalities are found within Indigenous feminisms (Cidro et al., 2020; Green, 2017) and literature that advocates for Indigenous relational ethics as a framework for nursing and cultural safety among HCPs (Best & Stuart, 2014; Bourque Bearskin, 2023; Brockie et al., 2023; Dion Stout, 2012; Downey, 2014, 2020; Fraser, 2022b; Kelly, 2024; Kelly et al., 2023; Kurtz et al., 2017; Ramsden, 2002).

The atrocities of healthcare experiments committed by the Nazi's ushered in a new era and urgency to develop ethical codes (e.g., the Nuremburg Code) for research and healthcare (Rogers et al., 2012; Shuster, 1997). The notion of *do no harm* to persons in our care is the essence of traditional bioethics. Bioethics emerged within a neoliberal and western scientific context which focused on individual rights, privacy, informed consent, and the rational and objective application of universal principles including, benevolence, non-maleficence, autonomy, and justice (Baylis et al., 2008; Gadow, 1999; Hess, 2001; Woods, 2012). These principles are to be applied at all times, but significantly come to the fore in situations when HCPs face morally distressing situations and bioethics are thus called upon to inform decisions and determine an ethically just course of action (Lechasseur et al., 2018; Milliken, 2018; Poikkeus et al., 2014).

Unfortunately, systemic racism, oppression, and violence against Indigenous Peoples are often normalized and may not trigger moral distress among settler HCPs, particularly when they are unaware of their complicity with oppressive systems, structures, and practices (Came & Humphries, 2020; Dion Stout et al., 2021; Downey, 2020; Fraser, 2022b; Kelly, 2024; Smye et al., 2023). One of the key research findings of my study was that CHNs struggled to recognize racism against their Indigenous clients, unless it was blatantly racist comments. For example, blatantly bad behaviour from other service providers directed at their Indigenous clients was labeled by CHNs as harmful and wrong. However, CHNs were not unequivocal that this bad behaviour was racism, particularly when clients' Indigeneity intersected with the stigma of substance use and homelessness. Normalized harm and (un)recognized racisms, problematizes the ways in which the need for ethical deliberations are often identified based on moral distress (Deschenes & Kunyk, 2020). CHNs experienced distress and potentially vicarious trauma from witnessing blatant racisms, overt stigmas and other forms of violence and discrimination against their clients and also from hearing stories about past atrocities against Indigenous Peoples, but they acknowledged that they were often oblivious to more systemic and structural forms of racism. They acknowledged that they still had much to learn before they could fully understand how colonialism and racism are currently being perpetuated within current systems, structures, and policies. Nurses must constantly struggle towards cultural safety, health equity, and understanding Indigenous relational ethics, and struggle against social inequities, which are often grounded in unethical and/or racist policies (Dion Stout, 2012; Downey, 2020).

We must also problematize the ways in which claims to objectivity are invoked to guide ethical decision making based on universal principles, despite potential for racial bias. Benevolence, which is a key principle within traditional bioethics, may also risk contributing to

paternalistic racism. White benevolence, saviorism, paternalistic racism and colour-blind racisms (e.g., meritocracy and the notion that we treat all people the same) is likely more common in healthcare than blatantly racist comments (Gebhard et al., 2022; Nath & Allen, 2022). This highlights the need for greater ethical sensitivity to all forms of racisms, and alternate ethical frameworks through which to analyze multiple intersecting oppressions in healthcare including racism, sexism, ableism, cisgenderism, heteronormativity, and colonialism. UNDRIP, Treaties, and human rights provide an ideal conceptual framework for nursing action on health disparities between Indigenous Peoples and settler Canadians (Bourque Bearskin, 2023; Came & Griffith, 2018; Craft & Lebihan, 2021; Dion Stout, 2012; Downey, 2020). Ethical obligations to anti-oppressive and anti-colonial nursing practices require a reconceptualization of nursing ethics from traditional bioethics to a relational approach (Dion Stout, 2012; Downey, 2020; Fraser, 2022b; Kelly, 2024; Pauly et al., 2021; Sherwin & Stockdale, 2017; Woods, 2012).

Relational ethics is not just a way to make decisions, but rather a way of being with others. Relationships are central within Indigenous ethics. Notions of respect, reciprocity, relational accountability, responsibility, and community are fundamental to Indigenous strands of relational ethics (Barlo et al., 2021; Dion Stout, 2012; Downey, 2014, 2020; Ermine, 2007; Fraser, 2022a, 2022b; Hurley, 2024; Kelly, 2024; Kelly et al., 2023; Kirkness & Barnhardt, 1991; Reo, 2019; Wilson & Wilson, 1998). Ermine (2007) described ethics “as the capacity to know what harms or enhances the well-being of sentient creatures” (p. 195). I argue that this capacity should be developed in relation to understanding structural violence and other intersecting oppressions as the essence of a nursing ethics oriented towards health equity, climate and planetary health, and social justice. Ermine (2007) highlighted relational responsibilities to others and “with our ethical standards in mind, we necessarily have to think about the

transgression of those standards by others and how our actions may also infringe or violate the spaces of others" (p. 195). Individuals are intertwined with others and environments, which refutes liberal ideals of discrete, circumscribed individuals as the basis for bioethics. Indigenous theories are not inherently part of a critical paradigm; however, emphasis on anti-colonialism and decolonization are defining features of *critical* Indigenous paradigms (Smith, 2021), which is an essential lens through which to understand Indigenous homelessness. Anti-colonialism shifts the relational frame to challenge thinking patterns, values, and beliefs that are bound up with Whiteness, settler colonialism, and patriarchy (Dion Stout, 2012; Downey, 2020; Green, 2017; Kelly & Chakanyuka, 2021; Patel, 2022). Therefore, an anti-colonial lens has the potential to change how we perceive of others and how we see and understand anti-Indigenous racism and homelessness and in turn begin to dismantle oppressive nursing behaviours and build more positive practices (Thistle & Smylie, 2020; Thistle, 2017).

Situating relational ethics within a critical paradigm shifts our focus towards prioritizing the needs of vulnerable and marginalized groups; however, privileged people may perceive these priorities to be in conflict with their individual rights and freedoms (Kenny et al., 2010; Sherwin & Stockdale, 2017; Woods, 2012). This conflict came into focus in the harm reduction debates currently ongoing in Ontario and across Canada described in previous chapters. Relational ethics also requires a shift from liberal notions of equality towards critical notions of equity. Jennings (2019) described traditional bioethics as an applied framework for decision making, and conversely, relational ethics as more of an interpretive lens to examine healthcare practices. Jennings and others suggested relational ethics are ideal policy analysis tools for ethical policy development and reorientation of public health policy towards equity (Baylis et al., 2008; Dion Stout, 2012; Downey, 2020; Hodgetts et al., 2021; Jennings, 2015, 2019; Kenny et al., 2010).

Relational ethics requires a paradigm shift from neoliberal ideals of individualism towards a notion of personhood as fundamentally relational (Baylis et al., 2008; Bergum & Dossetor, 2005; Dion Stout, 2012; Downey, 2020; Sherwin & Stockdale, 2017). Within most bioethics frameworks personhood is conceptualized as the "liberal ideal of an independent, rational, self-interested deliberator whose values are transparent to [themself]. Persons are conceived of as discrete and circumscribed, separate from one another, each with his or her own private interests that must be respected and accommodated" (Baylis et al., 2008, p. 5). Given the ways in which vulnerable individuals have been intentionally harmed, supposedly for the greater good of society (e.g., to develop scientific knowledge and medical treatments) it makes sense that individual rights were given primacy over community concerns in traditional bioethics (Shuster, 1997). However, this is not to say, from a relational ethics perspective that societal needs eclipse HCPs obligations to do no harm to individuals (Baylis et al., 2008). The concept of relational personhood makes clear the ways in which individuals are inseparable from their communities, and the ecological and social systems surrounding them (Baylis et al., 2008; Bergum & Dossetor, 2005; Dion Stout, 2012; Downey, 2020; Sherwin & Stockdale, 2017).

My situational analysis mapped out a relational ecological overview of situational elements that influenced CHNs relationships, which demonstrates the congruence between my relational ethics framework and SA methods. My analysis also identified backlash against people who use substances in public and/or are experiencing homelessness, and against harm reduction nurses and their approaches to care. These backlashes highlight how CHNs day-to-day work is inseparable from the broader sociopolitical arenas of healthcare and provincial politics. Moreover, Indigenous relational ethics is a key framework for understanding the ways in which people are inextricably bound to their sociopolitical and environmental surroundings.

Ethical Policy Making

Harm reduction is an ethical approach to guide nurses' interactions with people who are street involved and/or homeless. Given their life circumstances, people who are street involved often receive substandard healthcare because they are labeled as difficult, violent, socially deviant or criminal, and are therefore deemed unworthy of compassion and care by nurses and are often excluded from society more generally. People that are marginalized, homeless and/or street involved often have some of the greatest healthcare needs in society, but they are labeled as "frequent flyers" and their healthcare is rationed. Despite being the most in need of ethical nursing care, people that are labeled so called "frequent flyers" and "difficult patients" are the least likely to receive it. Therefore, harm reduction is congruent with nursing ethics that aims to promote equitable access to care on the basis of need, engage in shared decision making, and person-centered relational practices and uphold human autonomy and human rights. Harm reduction should also be utilized as an ethical framework for policy actions on the structural and SDH because people that are marginalized in healthcare may also be denied entirely their basic human rights within broader society.

Nursing scholarship and research ought to explore how relational ethics can be theoretically expanded and applied beyond the level of individual interactions. This may require looking beyond nursing scholarship to other disciplines to better understand political actions and the processes involved in policy making. Media and public opinion have a significant impact on policy making. As chapter 3 highlighted, politicians are increasingly becoming more polarized about healthcare in general and harm reduction in particular. At times ideology and public opinion more so than scientific evidence may drive health policy decisions. It is problematic to disregard best available scientific evidence in favor of ideologically driven policy making.

However, policy making in general is often more complex than simply making decisions based on scientific evidence. Sometimes scientific evidence is just emerging or lacking entirely because of a rapidly evolving situation or lack of funding to study an issue from multiple different angles. In addition to being evidence based, policies must also be ethical and balance individual rights/needs with the best interests of communities' health and wellbeing, accepted social values, and advancing population level health equity for all marginalized groups. Nurses must learn about mediatized policy making and how to influence public opinion, advocate to politicians, secure seats at policy tables, and partner with legal experts to take action within the courts.

Although, I fully support the need for political and legal recognition of oppressed groups, it is important to distinguish political recognition from the kind of mutual recognition that ideally may occur between people, for example, within the nurse-person relationship. Additionally, White CHNs in my study struggled to recognize racism. Therefore, despite their considerable compassion for Indigenous people living in homelessness, CHNs may not act against racism and colonialism because they may not recognize it. Recognition of anti-Indigenous racism also may not occur on a large scale among the Canadian public despite increasing education and awareness among many settlers. Coulthard (2007) critiqued the politics of recognition altogether. He suggested that recognition is an inadequate basis for a renewed relationship between Indigenous Peoples and settler Canadians, because recognition typically ends with cultural recognition and does not result in Indigenous sovereignty, nor does it result in mutual recognition at a societal level and true nation to nation relations between Indigenous Peoples and the Canadian state. Political and legal recognition is typically conferred collectively by society, but more specifically by those with political and economic power. Politicians appoint judges and other law makers and importantly, politicians make decisions and wield influence on the basis of

securing votes and appeasing corporate interests. Narratives pitting public interests (i.e., settler interests) against Indigenous rights are barriers to progress on the TRC Calls to Action (Jewell & Mosby, 2022). Policies generally require public support for them to be enacted by elected politicians, although unpopular policies have been pushed through by governments in the past.

Culturally Humble Praxis

Compassion and humility may need to become more widespread among individual members of the dominant society for political and legal recognition to occur, which highlights the need to focus on ethical relationships as foundational to social transformation. Cultural humility requires self-reflexive practices to identify where change is required. Yet, reflection alone is not enough—nurses must be willing and able to act. The concept of praxis is used in nursing as part of reflective practice. In this study I drew on Freire's (1971) conceptualization of praxis. Praxis, defined as reflection and action for the purpose of transformation, clearly describes a process. Moreover, Freire (1971) emphasized the importance of dialogue, mutual trust, and humility as part of this radical dialogical praxis. I suggest that a process of reflection and action that includes cultural humility might be conceptualized as *Culturally Humble Praxis*. I envision this concept as deliberate cycles of critical reflexivity and intentional action for the purpose of social transformation; an explicitly critical approach to self-awareness should form the theoretical foundation for this process. Conceptualizing cultural humility as a praxis shifts the focus from solely a reflective exercise towards anti-oppressive actions. However, critical interrogation of oneself in relation to others (i.e. relational ethics) must be undertaken prior to action to ensure that any action taken is meaningful and responsive to the needs of others. Freire (1971) argued "how can I dialogue if I always project ignorance onto others and never perceive my own" that only through humility can one reach the "point of encounter… [where] there are

only people who are attempting together, to learn more than they now know" (p.90). Anti-oppressive actions ideally must take place within multiple levels, including actions that seek to create culturally meaningful practices at the client level and community level engagement and political action, policy work, and advocacy.

Research Implications, Recommendations, and Specific Actions

In writing this dissertation, I became acutely aware of the dearth of empirical research on nurses' roles in colonialism. Nurses participated in residential schools, TB sanitoriums, Indian Hospitals, forced sterilization, and forced medical evacuations, but their roles are not well studied by historians, nor well documented in nursing literature. Additionally, these gaps may influence nursing interventions focused on education about the impacts of colonialism on Indigenous Peoples, because it does not confront nurses with the direct role nurses have, and have had, in causing the harm. The ways in which settler colonialism is bound up with nursing requires critical examination towards uncovering difficult truths and (re)orientating nursing practice to engage in anti-oppressive practices. The call for truth requires nurses to lean into the discomfort of their history and confront their ongoing complicity in government policies, broader systems and structures, and the settler colonial state that intentionally stole Indigenous land, culture, and children away from Indigenous families and communities living on Turtle Island.

Nursing must attend to both truth and reconciliation in nursing, and to date uncovering the truth of settler violence in nursing has received scant attention from settler nurse researchers. Nurses must engage in the uncomfortable work of uncovering our professions' unethical behaviours and human rights violations, past and present. Researchers must also expose nursing's roles in colonization. Based on my findings and experiences as a doctoral student at a school of nursing, I am doubtful that all schools of nursing and health care organizations across

Canada are working to advance the TRC Calls to Action with requisite urgency. Policies and practices consistent with truth and reconciliation must be implemented. I question when the TRC Calls to Action in health will be completed in their entirety. To address the overall lack of progress on the TRC, researchers must undertake more fulsome analyses of progress within the nursing discipline.

Future research must further expand theoretical understandings of anti-oppression approaches that attend to relational ethics and human rights and explore how to operationalize them in practice with Indigenous communities. Explorations of anti-colonial actions should also focus on policy work and community engagement. Decriminalization of substance use is essential to achieve health equity among Indigenous Peoples. Nurses in all practice areas must be enabled to engage in anti-racist action, which includes identifying and overcoming barriers to action. These are all research gaps that future research must seek to address. However, a national working group inclusive of Indigenous rights holders and national, provincial, and Indigenous nursing organizations must develop a collective action plan to move nurses beyond declarations of good intentions and to prevent piecemeal and siloed action by individual researchers and institutions. In Table 8.1, presented below, I propose recommendations based on implications of my findings, and I suggest a few ways nurses could transform nursing care and enhance health equity. Nursing recommendations related to academic research, can at times be broad and seem like they don't relate to nurses' practices or apply to smaller organizations; therefore, I offer some specific actions for nurses and organizational leadership. I also include future directions and a few recommendations for nursing academia, researchers, educators, and policy makers.

Table 8.1

Research Implications, Recommendations, and Specific Actions

Recommendation	Specific Nursing Actions
Fully implement UNDRIP into healthcare as it was intended internationally and as required under Canadian law.	• Read UNDRIP and reflect on the ways that you can implement the rights of Indigenous Peoples into your daily practices and ask your organizational leadership and colleagues to do the same. • Advocate that the CNA and CNO include UNDRIP in future iterations of their Codes of Ethics/Conduct and provide resources for nurses to learn more about it. • Call out and report violations of UNDRIP to those with authority to address it (e.g., supervisors, organizational leadership, regulatory colleges, human rights tribunals).
Work towards ending Indigenous homelessness and eliminating racism and discrimination in healthcare.	• Educate yourself on human rights frameworks and request that your organization provide human rights training that is relevant to your practice area. • Develop anti-racism policies that address more than just overt racism and violence (e.g., policies that ensure equitable access to care, support BIPOC staff to advance within organizations, and/or ensure culturally safe care, and address more insidious White racial behaviors that uphold racism). • Advocate with your Indigenous clients for access to SDH and support them to navigate discriminatory systems. • Read about racism, learn to identify more insidious and covert types of systemic racism and white racial behaviours that uphold it such as White benevolence. • Break the silence, call out all forms of racism. • Request time and leadership support to engage in systems level advocacy. If you are a leader—approve it. • Develop an action plan and collective messaging (e.g., to write to politicians or speak to media). • Together as an organization, invite policy makers to your workplaces and/or request meetings with them and ensure front line staff and people with lived expertise have opportunities to share their concerns. • Join nursing organizations or community groups that are engaging in political or legal action for social justice and basic human rights to health and housing. • Consider making charitable donations to Indigenous rights organizations that are taking legal action against discriminatory systems and advancing land claims.

Meaningfully advance the TRC Calls to Action in health towards completion.	• Read the TRC Calls to Action and reflect on ways that you can implement them into your daily practices and ask your organizational leadership and colleagues to do the same. • Take the time to read books by Indigenous authors and watch Indigenous films and learn about colonization and reconciliation from Indigenous perspectives. • Reach out individually as nurses, and collectively as organizations, to develop friendships and partnerships with local Indigenous community organizations. Improve understanding of their services and facilitate appropriate referrals to their organizations. • Develop an action plan for truth and reconciliation at your organization, ensure it is in collaboration with Indigenous community members and the plan has specific and measurable goals and timelines. • Advocate that the CNO develop mandatory training consistent with TRC Call to Action #24 that covers the same content aimed at students (e.g., human rights, UNDRIP, treaties) within Call to Action #23. • Advocate that the CNO revise their Code of Conduct Principle 2 to meaningful address colonization and anti-Indigenous racism to ensure the original spirit and intent of cultural safety is maintained. • Support recruitment and retention of Indigenous (and BIPOC) students and staff at your organization or school of nursing, through standing up for them when they experience discrimination and supporting them to advance in leadership areas.
Ensure equitable access to healthcare among Indigenous people experiencing homelessness.	• Ensure your organization is collecting race-based data and analyzing it regularly to evaluate equitable access to programs and services. • Reflect on the ways that you might be deterring access to care and work to improve your own practices. • Together with your colleagues, reflect on the ways that organizational policies and leadership practices might be deterring access to care and bring these issues to the attention of leadership. • Individually ask your Indigenous clients about barriers for them and their peers to access your programs and work to remove those barriers. • Host meetings and focus groups with Indigenous community members (e.g., service providers, Elders, people with lived experience) to explore how to improve culturally meaningful care and equitable

	access at your organization, provide country food and pay people for their time and expertise.
Increase access to cultural supports and harm reduction care among Indigenous People experiencing homelessness.	• Recognize Indigenous diversity in your practice areas, and within your geographical area. Educate yourself on some specific cultural practices and beliefs among the various First Nations, Inuit and Métis peoples that frequent your organization and live in your area. • Provide country food regularly. • Ask your organization to bring in Indigenous healers and Elders that offer cultural supports through a harm reduction focused approach. • Consider how to provide greater access to land-based healing within your organizations (e.g., transportation out of the city, canoeing, communal walks in parks and greenspaces, access to sit around a fire, gardening). • Hire more Indigenous staff including people with lived experience of homelessness and substance use (e.g., peers), ensure they are compensated fairly and have opportunities for career advancement.
Recommendations	Specific Actions for Research, Education, and Policy
Develop greater awareness of and expose the truths of nurses' historical and present roles in perpetuating and challenging racism and colonialism.	• Support in depth studies of nurses' roles in colonization and consider ways in which researchers and graduate students might access extant discursive/historical data. • Advocate that church and government records related to nurses' roles in colonization are made accessible to Indigenous communities, researchers, and historians. • Shift from a sole focus on overt and individual acts of racism/violence towards studies of systemic racism, racist policies, and more insidious forms of White racial behaviours from multiple different nurse and patient/client perspectives and practice areas.
Incorporate anti-racism and anti-oppression approaches into nursing education.	• Stop using cultural competency! • Teach why we are no longer using cultural competency approaches and the problematic colonial assumptions that are impeded within these nursing theories. • Understand the nuanced differences between critical reflection and reflexivity and explore ways to develop self-reflexive practitioners and anti-oppressive praxis.
Incorporate Indigenous theories and knowledges into the practice and discipline of nursing.	• Advance relational ethics as an overarching framework for cultural safety/humility and anti-oppressive nursing practice and education. Stop using cultural competency. • Further explore anti-oppressive actions identified in my study and develop the complimentary concepts of

	narrative care and healing centered engagement with Indigenous communities, Elders, and Indigenous people experiencing homelessness. • Ensure proper compensation of Indigenous research participants, Elders, and community advisors. • Reflect on problems of cultural appropriation and ensure Indigenous knowledges are protected and Indigenous Peoples are given credit/acknowledgment for their contributions to nursing knowledges.
Promote anti-racist policy making and harm reduction programs designed with, for, and by Indigenous people experiencing homelessness.	• Expose racist drug policies and enforcement practices and advocate for decriminalization. • Examine differential impacts of harm reduction policies and practices using an intersectional lens. • Involve Indigenous communities in policy making including Elders, service providers and people with lived experience.
Study nursing behaviours that uphold systemic oppressions (e.g., White benevolence and silence) and use an intersectional lens in this work.	• Expose White racial behaviours (e.g., paternalistic racism) that upholds racist power structures. • Learn about nursing silence with greater attention to power and gender. • Design educational interventions to teach nurses how to overcome silence and speak-out against racism and other forms of oppression.
Examine the role of media in health policy making and media's influences on nurses' beliefs and biases about Indigenous Peoples	• Conduct an in-depth review of extant media analysis studies on Indigenous issues and explore how these representations influence access to SDH (in progress). • Conduct media analysis studies related to racism in healthcare and media attention to Indigenous deaths in healthcare (e.g., Eschequan, Sinclair). • Explore mediatized policy making in the intersecting areas of substance use and homelessness and current political backlashes against harm reduction. Ensure attention to racially coded language. • Consider alternate sources of extant data to explore mediatized policy making (e.g., Greto (2023) and her use of FIPA to access government communications related to the Stop Overdose campaign).

Strengths and Limitations of My Study

There are a number of limitations within this study that must be acknowledged. First, as with all qualitative research, transferability of my findings to other practice settings are limited. Second, my knowledge and experience as a new researcher is still developing. My own potential blind spots related to my White worldviews and socialization as a settler colonial nurse are limitations for my research on racism and colonialism. This limitation required that I assume a learner stance and engage in critical reflexivity and ongoing discussions with mentors to challenge my perceptions. Some of my learning reflections are presented at the end of this chapter. The majority of my interview participants were also White settlers, which risked amplifying already privileged voices. However, it is important to turn the microscope around to examine Whiteness in nursing. My lack of insider knowledge in relation to Indigenous nursing history, leadership, advocacy, anti-colonial activism and scholarship was also a limitation. In the future, I would not hesitate to connect with the Canadian Indigenous Nurses Association (CINA) and Indigenous nursing scholars who conduct research in the substantive areas to guide my literature reviews and ensure greater inclusion of this important work.

Access to non-interview data were also limited, for instance, I did not have permission to conduct formal observations, nor did I have access to medical records, and/or internal organizational documents, and literature searches were a challenge as noted previously. I enriched my study with other sources of data to help overcome these limitations, including reflections on my nursing experiences, as well as analysis of extant publicly available discourse materials (e.g., websites, news media articles, Nightingales' historical report, coroner's report into Joyce Eschequan's death). My review of nursing websites should be expanded in the future. The websites I chose were limited to those that served mostly legal and regulatory functions, but

there are many nurses associations that have the potential to influence nursing policy and practice including the Canadian Federation of Nursing Unions (CFNU), individual provincial associations and unions such as the Registered Nurses Association of Ontario (RNAO) and Ontario Nurses Association (ONA), and Indigenous nursing organizations and websites such as CINA and Indigenous Primary Health Care Council (IPHCC). My media analysis was a minor component of the study and contributed to the broad relational ecological overview; however, I acknowledge that my knowledge of media studies was rudimentary. In the future, I would like to undertake a more fulsome and rigorous analysis of media discourses inclusive of extensive database searches, systematic screening, and theoretical sampling of media articles.

Additionally, my sample size was small compared to some larger scale qualitative studies. However, interviews were in-depth and I had large amounts of rich interview data to explore. My sample size was constrained by challenges with organizational permissions, recruitment challenges, a lack of funding, and limited personal resources as a sole researcher. Although I had intended to include homecare nurses that provide care (e.g., wound care, footcare, IV infusions) to homeless and marginally housed individuals, none of the homecare agencies that I approached agreed to participate. However, my sample of CHNs was cohesive, yet still diverse, and this is a strength. For example, community practice areas of my participants have nuanced differences, nursing outreach into shelters, and working within the walls of a CHC or SCS are not the same, but there are considerable overlaps. Additionally, CHNs had often worked for multiple community care organizations, or agreed to participate on their own time unaffiliated with their organization, which contributed to greater insights into organizations beyond the three organizations that agreed to participate. CHNs that had worked in hospitals also contrasted their harm reduction experiences in the community to that of acute care. Perspectives

of CHNs from different organizations and programs offered important insights into organizational and systems level factors that influenced anti-colonial struggles among CHNs.

I acknowledge that my findings are bounded within community-based harm reduction practice settings, and the geographical and urban setting of one particular city in Ontario. Some anti-oppressive actions and relational practices that emerged in my findings may be usefully applied in all areas of practice, including acute care. However, I argue that transferability of my findings to acute care must be approached with extreme caution. As a nurse, I have practiced in both acute care and in the community, and in both of these practice areas I encountered Indigenous persons living with homelessness. Indeed, my clinical practice experiences were part of the impetus for this research project. Based on my practice experiences, I suggest perspectives of CHNs should be explored separately from acute care nurses' perspectives for the following reasons: 1) CHNs have greater exposure to peoples' living conditions and daily realties, and thus it is reasonable to expect that overall, CHNs have greater awareness of SDH than acute care nurses possess; 2) CHN's nurse-person relationships tend to develop over a longer period of time compared to acute care; therefore, relational practices may differ; and 3) nurses have different experiences and skills in advocacy between acute and community care. Advocacy is a significant part of CHN's nursing practices (Etowa & Hyman, 2022). Advocacy and political action are important anti-oppressive actions nurses can take against colonialism and systemic racism.

Horrill (2021) noted that among oncology nurses, discourses of individualism and egalitarianism combined with a lack of awareness of structural violence resulted in victim blaming and judgmental attitudes toward Indigenous Peoples. I suggest that among CHNs participating in my study that their inaction did not primarily result from a lack of awareness of SDH. To my mind, many nurses that do outreach work demonstrated greater understanding and

compassion for individuals suffering from the ill effects of homelessness, substance use, and mental illness compared to some of my colleagues in acute care. Many CHNs, and outreach nurses in particular, witness first-hand the lived realties of homelessness (Paradis-Gagné et al., 2020; Pauly, 2005, 2014; Weber, 2019), which suggested that overall CHNs may have greater awareness of the impact of structural violence on health-related choices and behaviours than their acute care counterparts. I firmly believe that the educational needs and support required to enable anti-colonial action among CHNs working with homeless communities differs from that of acute care nurses working in hospitals, or nursing professors and students working and studying in schools of nursing. Therefore, my research exploring CHNs' perspectives is requisite to tailor reconciliation efforts to this specific practice area and further research is needed to understand the contextual differences in other practice areas and specialties within nursing.

Racism and Me—Personal Reflections on Learning About Racism

In the previous chapters, I explored key concepts and controversies about race and racism. These concepts are important to anti-racist nursing research, education, theory, and practice. However, CRT and Whiteness studies are sometimes controversial and actions rooted in these theories at times are problematically displayed as evidence of anti-racism when they may instead be empty declarations of allyship and virtue signaling (Žižek, 2021). These practices often come to the fore during exercises where one describes their positionality and declares their White privilege and guilt accordingly (Haghiri-Vijeh, 2022; Nath & Allen, 2022; Phyfer et al., 2020; Snelgrove et al., 2014). However, I argue that reflecting on power and positionality is critically important, particularly because being a White settler emplaces me in a relationship to Indigenous Peoples and their lands. Therefore, I proceed with caution as I offer some personal reflection on my journey towards learning about racism and anti-racist practices. I still have a

very long ways to go, but I hope that other White nurses might learn from my missteps and the invaluable insights of people that have expended the energy to mentor me.

Despite the importance of conceptualizing problems in order to find solutions, a recent critical interpretive synthesis by Collier-Sewell (2023) found that nursing literature on racism rarely defined the concept of racism and even less frequently defined race. The lack of definitions in the nursing literature might suggest that the terms race and racism are self-evident and common sensical, which is hardly the case. Race and racism are complex terms with a broad empirical and theoretical literature base targeting both academic audiences and the general public. I struggled in writing my dissertation to decide which definitions of racism to use. I found myself going back and forth between definitions and theories about racism. I wondered if I was drawn to certain definitions because of my own White fragility. For example, I initially chose a definition that emphasized how systemic racism operates independently of the intentions, behaviours, and beliefs of the majority of people within the system, which supports the claim that systemic racism exists in public institutions (e.g., healthcare, policing, government), but not all employees (e.g., nurses, police officers) in the system are racist. However, I also did not want to let White people and my own Whiteness off the hook. Therefore, I would turn back to definitions that clearly intended to hold White people accountable for racial inequities (e.g., definitions of racism that emphasized that all White people are racist and only White people can be racist because racism is a system that White people benefit from and overwhelmingly have power to control). Definitions such as the one above highlights that White supremacy is responsible for racial inequities on a global scale, which is true, and offer insight into White people's racisms that are true much of the time.

However, I suggest that inserting more nuance into theoretical constructs of racisms and race is critically important to moving the conversation forward and not because we need to pander to White Fragility. White people need to lean into uncomfortable conversations about racial inequities and injustice. “To be racist is to constantly redefine racist in a way that exonerates one’s changing policies, ideas and personhood” (Kendi, 2019, p. 15). However, sweeping generalizations and a lack of nuance creates a shaky foundation for critical discussions about systemic racism and opens research to criticism and unnecessary debate. Additionally, some definitions of race, racist, racisms, etc., may problematically recenter Whiteness, create rigid binaries, and deny that BIPOC peoples have power, or suggest that they are outside of social systems entirely (I am aware that I am also creating binaries and centering Whiteness). Furthermore, when racism and racist are defined in such a way that they exclusively apply to White people in White supremacist societies we marginalize scholarly work from many places around the world. This suggests that BIPOC peoples that live outside of White wealthy nations can’t use the theoretical construct of racism to explore racial oppressions that occurs among and between non-White racial/ethnic groups in their own nations.

I realize that in the previous chapters, I did not offer any definitive definitions of race and racism. I think a dialogue is more important than a glossary of concise definitions. I suggest that there are multiple definitions of racism, racist, race, etc., that may be theoretically useful for different purposes. I agree academically with Kendi’s (2019) definitions of racist and anti-racist which is inclusive of inaction against racist policies. I also agree with White critical race scholars DiAngelo (2018) and Frankenberg (1988) that exposing how everyday White people uphold White supremacist systems is critical to eliminating systemic racism. But I question whether reconceptualizing the term racist person has been productive in moving conversations forward

among the general public. I argue that the historical image of a racist as an “ignorant schmuck” is etched in most peoples’ minds. I think the concept of complicity is conceptually accurate and carries less baggage. Everyday folks might be more open to hearing how they are complicit with systemic racism or racist policies rather than being called a racist for their inaction.

Silence was one of the predominate forms of complicity among CHNs in this study. However, I struggle with solely using DiAngelo's (2018) White fragility to explain silence among nurses. Her theory lacked nuanced discussions of intersectionality and was developed within a specific context of White behaviours observed during anti-racism training, which is arguably far removed from the kinds of power dynamics nurses (mostly female) experience within physician dominated healthcare institutions, speaking out against institutionalized racism or calling out supervisors/leadership in workplace settings (Bell, 2024). Silence demands greater attention by White nurses and an intersectional lens is essential to research involving power.

Additionally, I argue that it is important to connect racism to an ideology and system (i.e., White supremacy) rather than immutable physical characteristics (i.e., White skin color). Language matters and conceptualizing racism as innate precludes change and concedes defeat before we even begin. Racist is what you do and not who you are. There is a subtle but important difference between telling someone “you *are a* racist” and “you are *being* racist” because one implies a temporary state based on actions/beliefs, while the other implies a permanent state and immutable personality trait (Kendi, 2019). However, both phrases are likely to trigger defensiveness because the term racist is associated with overt forms of racism, ignorance, immorality, hate, and intent to cause harm. The term racist emerged during a time when individual acts of racism were predominantly overt and emboldened by intentionally and unapologetically overt racist policies. Racial prejudice was acceptable and discrimination was

ratified in federal and local laws, in numerous countries. However, racism evolved to be more insidious and covert, albeit no less harmful. Unfortunately, in current political climates in Europe and North America overt racism is once again being emboldened by right wing populist politicians such as Donald Trump.

To provide some conceptual clarity on my understandings of racism, I highlight a few key assumptions that I believe are central to move conversations forward. First, European settler colonial systems and imperialism were historically premised on White supremacist ideology. Second, there have been no radical changes to Canadian political systems; therefore, our current systems remain White supremacist. Third, social structures are not devoid of individual actors and no one is completely outside of the system. Therefore, everyone to varying degrees is complicit in systemic racism, regardless of awareness, intent, or skin color. Fourth, White supremacist systems benefit all White settlers and perpetuate racial inequities. Race is not the only axis of oppression, and some White settlers benefit very marginally from their Whiteness. Fifth, wealth continues to accrue exponentially among a few historically privileged people that were typically White men. This wealth was disseminated to their families and represents intergenerational wealth that originated in the colonial oppression of Indigenous Peoples and stolen lands. Sixth, White settlers are more likely to actively resist anti-racist changes that they perceive will disadvantage them. Inaction is also a form of complicity. White settlers and BIPOC peoples alike may indirectly uphold systemic racism through inaction, but White settlers are more likely to directly uphold systems and policies that perpetuate racial inequity because they have more power in the systems that were designed to benefit them. Therefore, complicity increases relative to the agency and power a person has to make anti-racist changes within their own practices, and to change organizational policies and larger scale systems. Power is typically

concentrated in the hands of White settlers, and therefore, they are more complicit in systemic racism than BIPOC peoples. Seventh, concentrating on a few bad apples will not eliminate racial inequities. Nor can we educate our way out of the problem. Systemic changes are needed. Throughout this thesis I developed and expanded on the key assumptions above.

As I have learned more about racism, colonialism, and whiteness I am better able to keep my behaviours and beliefs rooted in Whiteness in check. My compassion and desire to help still risks slippage into White benevolence, paternalistic racism, and White saviorism. I continually need to check my assumptions. Paternalistic assumptions are just as problematic as other anti-Indigenous stereotypes in nursing. Supporting Indigenous resistance is critical to systemic changes that will likely benefit everyone in the end. Sometimes this means stepping back and being a silent supporter, but not always. I still struggle with deciding when to speak up and when to step back and remain silent. I tend toward the latter because of my introversion, aversion to conflict, and desire to be liked, but that means that I too often let problematic comments slide. I also learned that these entire confessional exercises, including declarations of White privilege and claims of allyship, are often performative, symbolic, and a form of virtue signaling.

Acknowledging one's own White privilege is common practice as part of anti-racism trainings and discussions. However, performative practices of confessing White privilege are highly problematic, both as a move to claim innocence and because it focuses greater attention on individuals rather than systems and policies, and recenters Whiteness. This practice implies that one's unfair advantages are simply bestowed upon one's self and that acknowledging White privilege somehow renders it less problematic. Additionally, if you confess your White privilege then you may claim to be less racist than others who are unaware or refuse to acknowledge their White privilege. The term complicity suggests that one had a part in gaining their unfair White

racial advantages; and therefore, also have a responsibility to rectify the problem. There are risks that focusing on whiteness in order to make it visible, to deconstruct it and to move it to the margins, might problematically recenter whiteness. I am not really sure how best to approach exploring positionality and self-reflexive exercises to minimize these risks. I think learning from our mistakes and the mistakes of others are important opportunities for growth. Anti-racist learning is hard work that is never complete and I'm never going to get it perfect. Reflexivity is also an important part of cultural humility that requires having honest and open conversations with others that can help us see things in a different light. Through this research project I have begun to unravel settler colonialism from within my own theoretical understandings about nursing. I plan to continue this journey long after this project is complete because cultural humility is a life-long praxis.

Conclusions and Future Directions

Considerable research focused on experiences of Indigenous persons accessing care in hospitals and emergency departments, but nursing care must be tailored to the practice area. Community-based harm reduction and nursing outreach practices bring care to homeless communities, providing healthcare where and when it is needed most, particularly for persons with complex physical health needs, mental illness, and substance use (Paradis-Gagné et al., 2020; Pauly, 2014; Weber, 2019). Building and sustaining relationships are vital to providing care to persons experiencing homelessness, but can be time consuming and difficult to achieve due to high levels of trauma, substance use, stigma, and mistrust of the healthcare system (MacDonald & Cote, 2022; McCallum et al., 2020). Few studies have explored CHNs relational practices with people experiencing homelessness (Weber, 2019), and I found no studies that examined nurses' perspectives on their struggles against colonialism in the area of community

health nursing. Therefore, my research addressed an important gap in the literature.

Etowa and Hyman (2022) argued, and I agree, that CHNs have requisite knowledge of structural determinants of health and advocacy skills to collectively participate in systems level transformation towards health equity, provided they are brought into the political fold. I further argue that there is untapped potential for anti-colonial action among many CHNs with their existing knowledge of relationship building and advocacy skills. At times, community health nursing has been a site of political resistance, for example, street outreach and harm reduction nurses have engaged with the mantra ‘nothing about us without us” and have taken political and legal action with people who use drugs (e.g., unsanctioned SCS, decriminalization of drugs; HRNA v BC., 2023; Kelsall et al., 2025; Lightfoot et al., 2009). At the outset of my study, I questioned, why have struggles against systemic racism and Indigenous homelessness not been taken up with the same vigor, what are barriers to action and how can nurses be enabled to act?

My situational analysis identified situational elements that (dis)enabled action such as leadership, funding constraints, and training gaps, as well as internal struggles to see racism and overcome silence. There were also several promising practices within organizations, and CHNs engaged in many, albeit somewhat invisible, anti-oppressive actions and relational practices. I argue that CHNs have an ethical imperative to engage with Indigenous Peoples in anti-colonial struggles to address root causes of Indigenous homelessness and ensure that they have equitable access to healthcare and harm reduction programs that are free from racism and discrimination. Additionally, nurses, regardless of practice area, must reflect on their complicity within social and political systems that continuously perpetuate health inequities among Indigenous Peoples (Bell, 2023). Harm reduction programs may not be welcoming to BIPOC staff and clients (Godkhindi et al., 2022). CHNs also suggested the Indigenous people experiencing homelessness

did not have equitable access to harm reduction care within their organizations.

In my work as a nurse and researcher, I seek to better understand how nurses can cultivate cultural safety, develop meaningful, trusting, compassionate relationships with Indigenous persons experiencing homelessness, engage in anti-colonial struggles, and promote relational ethics and healing-centered community engagement. Importantly, the person receiving nursing care ultimately determines whether care is culturally meaningful and safe or not (FNHA, 2020). I started this line of inquiry with the perspectives of nurses, because these perspectives were largely absent from the Canadian literature on anti-Indigenous racism in healthcare (Bell, 2021, 2023; Horrill, 2021). My intention is that future studies will bring together the perspectives of nurses and Indigenous community members to collaborate and identify what CHNs and their respective organizations can do to build trust and provide culturally meaningful and safe care with people living through homelessness.

Ideally, my research will result in improved understandings of cultural safety within community health nursing and inform anti-oppressive practices within the nursing profession. I hope to contribute to reconciliation in healthcare more generally, through developing a greater awareness of how nurses can struggle against settler colonialism that is imbedded in the nursing discipline. My future intentions for my program of research and as a nurse in clinical practice are to collaborate with other CHNs and Indigenous community members to promote health and healing through anti-colonial action. Additionally, by identifying conditions that enable and/or constrain anti-oppression work among CHNs, I hope that they might be better supported by their respective organizations to act. But, most importantly, I hope my research inspires CHNs to take up anti-colonial struggles with Indigenous communities and take action on the socio-political roots of urban Indigenous homelessness.

Appendices and Supplementary Material

Appendix A: Interview Guide

1) Demographics

Tell me a bit about yourself and your nursing background: age, education, years of experience, years in current role. Why did you choose to work in this role? How would you describe your cultural identity and gender? Have you taken additional formal training in this area? Did your organization support this training (pay for course or time off work)?

2) Indigenous Homelessness

Tell me a bit about Indigenous homelessness? How would you describe the oppressions that your indigenous clients face? Tell me a little about your encounters and relationships with your Indigenous clients? What are barriers to them accessing care? Do you feel Indigenous people have equal access to your organization's services? Race-based data? Do you feel that you have power in your nursing practice to address any of the issues that you described?

3) Racism in Healthcare

Have any of your clients ever disclosed experiences of racism in healthcare to you? How did you respond? Do you feel prepared to respond when you witness racism? How would you describe nursing practices that are anti-oppressive or anti-racist? What enables you to engage in these practices? What are some barriers to you engaging in these practices? What supports or training do you think would be helpful to engage in anti-racism?

4) Advocacy and Anti-Oppressive Action

Tell me a bit about how you engage in advocacy for your clients? How does your organization engage in advocacy? How might you take action ***with*** your clients or communities against racism

and oppression in the future? What would motivate you to do so? What enables you to advocate? What are barriers to your advocacy and anti-oppressive action at the individual, organizational or systemic level? What training or organizational supports do you require to engage in advocacy work within your CHN practice?

5) **TRC Calls to Action and Cultural Competency/Safety**

How would you describe cultural safety? How is it different from cultural competency? Tell me a bit about how you incorporate cultural safety into your nursing practice? Do you feel competent in your understandings of Indigenous issues related to the population you serve? How does your organization promote cultural safety/competency? Did you learn about cultural safety/competency/Indigenous issues in nursing school?

Tell me a bit about how truth and reconciliation relates to your nursing practice? The TRC Calls to Action called for nurses to have training on UNDRIP, Treaties, and human rights as part of cultural competency. How do you perceive that UNDRIP, Treaties, and human rights relate to your nursing practice? What role do you perceive CHNs have in advocating for Indigenous rights? How does your organization promote truth and reconciliation? What additional training or supports do you require related to Truth and Reconciliation?

6) **Closing Questions**:

How important is this issue for you? Is there anything else this brings up for you or that you want to mention?

Appendix B: Scoring Matrix and Website Evaluation Criteria

Scoring Matrix and Website Evaluation Criteria	
Anti-Oppression Content and Commitments	
1) Overall it was easy to navigate to anti-oppression content. • Links to internal webpages or practice documents on anti-oppression clearly visible on homepage. • Links to external webpages on anti-oppression clearly visible on homepage. • Internal webpages, practice documents, or external links found using search function.	Agree Disagree
2) College displayed evidence of commitment to anti-oppression and TRC on homepage. • Homepage specifically mentions anti-racism. • Homepage specifically mentions Truth and Reconciliation. • Homepage mentions other anti-oppression concepts: cultural safety/competency/humility or social justice.	Agree Disagree
3) College had web pages dedicated to anti-oppression. • Detailed and easy to understand approach to anti-oppression work. • Specifically mentions racism and/or oppression. • Specifically addresses/describes the problem of colonization. • Critical underpinning (e.g., cites critical race or Indigenous scholars). • Number of documents _____	Agree Disagree
4) Links to external websites were relevant and assisted with understanding anti-oppression or TRC action. • Links to Indigenous organizations. • Links aid understanding of racism/oppression. • Number of links____	Agree Disagree
5) College had land acknowledgement and/or declarations against anti-Indigenous racism. • Land Acknowledgments clearly visible on homepage. • College made declarations against anti-Indigenous racism within land acknowledgment or separate declaration on homepage or another webpage.	Agree Disagree
Practice and Policy Documents	
6) RN Practice Standards or Entry-level Competencies are informed by anti-oppression approach. • College had separate practice standard dedicated to anti-oppression. • ELC deviates from CCRNR ELCs to include greater attention to TRC, equity, anti-racism, cultural safety.	Agree Disagree
7) RN Code of Ethics are informed by anti-oppression approach. • Contains Link to CNA 2017 Code of Ethics was standard approach. College deviating from CNA to include greater attention to TRC, equity, anti-racism, cultural safety would be above average.	Agree Disagree
8) College had additional practice documents dedicated to anti-oppression (e.g., practice spotlights) • Detailed and easy to understand approach to anti-oppression work. • Specifically mentions racism and/or oppression. • Specifically addresses/describes the problem of colonization.	Agree Disagree

• Critical underpinning (e.g., cites critical race or Indigenous scholars). • Number of documents _____	
Accountability and Transparency	
9) College displayed evidence of holding membership accountable to anti-oppression learning. • Separate anti-oppressive training required as part of license renewal. • Mandatory self-assessment or practice standard as part of license renewal.	Agree Disagree
10) College displayed evidence that protecting the public from racism in healthcare is a priority. • College provides information specifically about filing a complaint about racism or resources for Indigenous clients/patients. • College states that they have Indigenous representation on hearing and/or discipline committees. • College has evaluated their complaints process related to anti-Indigenous racism (e.g., collecting and summarizing complaints related to racism or assessing barriers to filing racism complaints). • College has published aggregated data of public complaints about racism and anti-Indigenous discrimination among their membership and summarized results of disciplinary decisions (goes beyond the searchable list of hearings/decisions about individual nurses).	Agree Disagree
11) College's processes for implementing anti-oppression are transparent and accountable to the public. • Data collection and research is published on websites. • Documents and educational material publicly available on website. • Anti-racism or TRC committees listed on website.	Agree Disagree
12) College displayed evidence of involving Indigenous Peoples • Reports Indigenous representation on board of directors or leadership. • Engagement guidelines for working with Elders and consulting Indigenous community members/groups. • Documents/education materials show evidence of Indigenous involvement. • College reported that land acknowledgment was developed in collaboration with local Indigenous Peoples.	Agree Disagree
Progress and Implementation of TRC Calls to Action	
13) College displayed evidence of commitment TRC Calls to Action. • Plan and timeline reported on website. • Declarations or commitments to TRC and/or anti-racism made by organization on behalf of membership.	Agree Disagree
14) College displayed evidence of updated content. • Year 1 • Year 2	Agree Disagree
15) College displayed evidence of improved accountability measures. • Year 1 • Year 2	Agree Disagree

Appendix C: Registered Nurse Practice Standards

CCRNR (2018) entry-level competencies (ELC) are divided based on 9 nursing roles: clinician, professional, communicator, collaborator, coordinator, leader, advocate, educator, scholar. The following competencies are relevant to ant-oppression, (ELC are direct quotes, numbered according to the CCRNR (2018) and listed under the role where they are found in the report as they do not provide page numbers):

> **Clinician:** *1.3 Uses principles of trauma-informed care which places priority on trauma survivors' safety, choice, and control. 1.26 Adapts practice in response to the spiritual beliefs and cultural practices of clients.*
>
> **Professional***: 2.5 Identifies the influence of personal values, beliefs, and positional power on clients and the health care team and acts to reduce bias and influences.*
>
> **Leader***: 6.1 Acquires knowledge of the Calls to Action of the Truth and Reconciliation Commission of Canada. 6.7 Takes action to support culturally safe practice environments.*
>
> **Advocate:** *7.3 Advocates for the use of Indigenous health knowledge and healing practices in collaboration with Indigenous healers and Elders consistent with the Calls to Action of the Truth and Reconciliation Commission of Canada.7.4 Advocates for health equity for all, particularly for vulnerable and/or diverse clients and populations. 7.11 Uses knowledge of population health, determinants of health, primary health care, and health promotion to achieve health equity. 7.14 Uses knowledge of health disparities and inequities to optimize health outcomes for all clients.*
>
> **Educator:** *8.3 Selects, develops, and uses relevant teaching and learning theories and strategies to address diverse clients and contexts, including lifespan, family, and cultural considerations.*
>
> **Scholar***: 9.3 Engages in self-reflection to interact from a place of cultural humility and create culturally safe environments where clients perceive respect for their unique health care practices, preferences, and decisions.*

CCRNR (2012) competencies report provided additional context for the development of ELC. The following competencies were most relevant to anti-oppression work. All competencies are direct quotes, numbered according to the CCRNR (2012) report:

> *35. Incorporates knowledge of the origins of the **health disparities and inequities** of Aboriginal Peoples and the contributions of nursing practice to achieve positive health outcomes for Aboriginal Peoples (p.13).*
>
> *36. Incorporates knowledge of the health disparities and inequities of vulnerable populations (e.g., sexual orientation, persons with disabilities, ethnic minorities, poor, homeless, racial minorities, language minorities) and the contributions of nursing practice to achieve positive health outcomes (p.13).*
>
> *42. Negotiates priorities of care and desired outcomes with clients, demonstrating **cultural safety**, and considering the influence of positional power relationships (p.13).*
> *73. Takes action to minimize the potential influence of personal values, beliefs, and positional power on client assessment and care (p.16).*
>
> *95. Supports healthy public policy and principles of **social justice** (p.19).*

Appendix D: Ethics Certificate

23/08/2023

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-06-23-8438
Titre du projet / Project Title	Exploring Anti-Colonial Struggles in Indigenous Homelessness and Community Health Nursing
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	23/08/2023
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	22/08/2024

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Julie WILLIAMS	École des sciences infirmières / School of Nursing	Chercheur Principal / Principal Investigator
J. Craig PHILLIPS	École des sciences infirmières / School of Nursing	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

References

Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing, & Canadian Nurses Association. (2009a). *Cultural competence and cultural safety in First Nations, Inuit and Métis nursing wducation: An integrated review of the literature*. https://www.casn.ca/2014/12/making-happen-strengthening-first-nations-inuit-metis-health-human-resources/

Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing, & Canadian Nurses Association. (2009b). *Cultural competence and cultural safety in nursing education: A framework for First Nations, Inuit and Métis nursing*. https://www.casn.ca/2014/12/making-happen-strengthening-first-nations-inuit-metis-health-human-resources/

Adlam, J. (2020). No room at the inn? Re-imagining social inclusion at the intersections between climate change, globalisation, homelessness, and human migration. *Journal of Social Work Practice*, *34*(4), 379-392.

Al-Chami, M. H., Gifford, W., & Coburn, V. (2024). A visionary platform for decolonization: The Red Deal. *Nursing Philosophy*, *25*(1), e12471.

Alaazi, D. A., Masuda, J. R., Evans, J., & Distasio, J. (2015). Therapeutic landscapes of home: Exploring Indigenous peoples' experiences of a housing first intervention in Winnipeg. *Social Science & Medicine*, *147*, 30-37. https://doi.org/10.1016/j.socscimed.2015.10.057

Albougami, A. S., Pounds, K., & Alotaibi, J. (2016). Comparison of four cultural competence models in transcultural nursing: A discussion paper. *International Archives of Nursing and Health Care*, *2*(3), 1-5.

Albrecht, J. A. (2024). Motherhood, religion, and feminism. Colonial encounters, intersectional identities. In S. Sharma, S. Hawthorne, & D. Llewellyn (Eds.), *Bloomsbury Handbook of Religion, Gender and Sexuality* (pp. 311-324). Bloomsbury Digital Resources. https://doi.org/10.5040/9781350257207

Alfred, T. (2009). Colonialism and State Dependency. school of Indigenous Governance, University of Victoria. *Journal of Aboriginal Health*.

Allan, B., & Smylie, J. (2015). *First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous Peoples in Canada: A discussion paper*. Well Living House: Wellesley Institute. https://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Full-Report-FPSCT-Updated.pdf

Allen, D. G. (2006). Whiteness and difference in nursing. *Nursing Philosophy*, *7*(2), 65-78.

Alligood, M. (Ed.). (2018). *Nursing theorists and their work* (9th ed.). Elsevier.

Andersen, C., & Walter, M. (2013). Deficit Indigenes. In *Indigenous statistics: A quantitative research methodology* (pp. 21 – 40). Walnut Creek: Left Coast Press.

Anderson, E. (2021). Sartre's affective turn: Shame as recognition in the 'the look'. *Philosophy Today*, *65*(3), 709-726.

Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Khan, K. B., Kirkham, S. R., Lynam, J., Semeniuk, P., & Smye, V. (2003). "Rewriting" cultural safety within the postcolonial and postnational feminist project: Toward new epistemologies of healing. *Advances in Nursing Science*, *26*(3), 196-214.

Anthony, T., & Hohmann, J. (2024). Indigenous housing rights and colonial sovereignty: Self-determination and housing rights beyond a White possessive frame. *Social & Legal Studies*, 09646639241227120.

Applebaum, B. (2013). Vigilance as a response to white complicity. *Educational Theory*, *63*(1), 17-34.

Ariss, R. (2021). Bearing witness: Creating the conditions of justice for First Nations children. *Canadian Journal of Law and Society/La Revue Canadienne Droit et Société*, *36*(1), 113-133.

Arriagada, P., Hahmann, T., & O'Donnell, V. (2020). *StatCan COVID 19: Data insights for a better Canada, Indigenous people in urban areas: Vulnerabilites to the socioeconomic impacts of COVID 19*. Ottawa, ON: Government of Canada Retrieved from https://www150.statcan.gc.ca/n1/pub/45-28-0001/2020001/article/00023-eng.htm

Asuquo, E., Etowa, J. B., Gifford, W. A., & Holmes, D. (2016). Nurses' involvement in HIV policy formulation in Nigerian health care system. *Journal of AIDS and Clinical Research*, *7*(7), 1.

Atleo, C., & Boron, J. (2022). Land is life: Indigenous relationships to territory and navigating settler colonial property regimes in Canada. *Land*, *11*(5), 609.

Bailey, A., & Masuda, J. R. (2024). Demarking a cordon therapeutique through Vancouver's liquor license moratorium for the Downtown Eastside: 1973–1988. *The Social History of Alcohol and Drugs*, *38*(2).

Baker, P., Friel, S., Kay, A., Baum, F., Strazdins, L., & Mackean, T. (2018). What enables and constrains the inclusion of the social determinants of health inequities in government policy agendas? A narrative review. *International Journal of Health Policy and Managment*, *7*(2). https://doi.org/10.15171/ijhpm2017.130

Balaban, K. (2023). *A national council for reconciliation: Challenges and opportunities of Bill C-29*. T. Y. Institute. https://yellowheadinstitute.org/2023/09/28/a-national-council-for-reconciliation/

Baldwin, C. (2006). The narrative dispossession of people living with dementia: Thinking about the theory and method of narrative. In G. Rosenthal, K. Milnes, C. Horrocks, N. Kelly, B. Roberts, & D. Robinson (Eds.), *Narrative, Memory & Knowledge: Representations, Aesthetics, Contexts* (pp. 101-109). University of Huddersfield.

Baldwin, C. (2015). Narrative ethics for narrative care. *Journal of Aging Studies*, *34*, 183-189.

Barker, A. J. (2015). 'A direct act of resurgence, a direct act of sovereignty': Reflections on Idle No More, Indigenous activism, and Canadian settler colonialism. *Globalizations*, *12*(1), 43-65.

Barker, B., Norton, A., Wood, S., Macevicius, C., Hogan, K., Cadieux, K., Meilleur, L., Nosyk, B., Urbanoski, K., & Pauly, B. (2025). Implementation of risk mitigation prescribing during dual public health emergencies: A qualitative study among Indigenous people who use drugs and health planners in northern British Columbia, Canada. *International Journal of Drug Policy*, *136*, 104679.

Barlo, S., Boyd, W. E., Hughes, M., Wilson, S., & Pelizzon, A. (2021). Yarning as protected space: Relational accountability in research. *AlterNative: An International Journal of Indigenous Peoples*, *17*(1), 40-48.

Battiste, M. (2016). Research ethics for protecting Indigenous knowledge and heritage: Institutional and researcher responsibilities. In N. K. Denzin & M. D. Giardina (Eds.),

Ethical Futures in Qualitative Research: Decolonizing the Politics of Knowledge (pp. 111-132). Routledge

Baylis, F., Kenny, N. P., & Sherwin, S. (2008). A relational account of public health ethics. *Public Health Ethics*, *1*(3), 196-209.

Belanger, Y. D., Awosoga, O. A., & Weasel Head, G. (2013). Homelessness, urban Aboriginal people, and the need for a national enumeration. *Aboriginal Policy Studies*, *2*(2), 4-33.

Bell, B. (2021). White dominance in nursing education: A target for anti-racist efforts. *Nursing Inquiry*, *28*(1), 1-11. https://doi.org/10.1111/nin.12379

Bell, B. (2023). *The mobilization of anti-racism here is like squeezing a square peg through a round hole: A critical qualitative inquiry into anti-racism in settler-colonial Canadian nursing education* [Doctoral Dissertation, University of Victoria]. Victoria.

Bell, B. (2024). "We'd really love to but we're really busy": Silence, precarity and resistance as structural barriers to anti-racism in nursing education. *Journal of Advanced Nursing*, *80*(1), 214-225.

Benji, J., Tomasky, G., Kaufman, K., & Miles, R. (2021). Impacts of COVID-19 on Indigenous communities in Canada. *The Health & Fitness Journal of Canada*, *14*(4), 22-34.

Benoit, A. C., Cotnam, J., O'Brien-Teengs, D., Greene, S., Beaver, K., Zoccole, A., & Loutfy, M. (2019). Racism experiences of urban Indigenous women in Ontario, Canada:"We all have that story that will break your heart". *International Indigenous Policy Journal*, *10*(2), 1-27. https://doi.org/10.18584/iipj.2019.10.2.1

Benoit, C., Carroll, D., & Chaudhry, M. (2003). In search of a healing place: Aboriginal women in Vancouver's downtown eastside. *Social Science & Medicine*, *56*(4), 821-833.

Benzie, R. (2024a, Dec 5, 2024). Doug Ford preparing to override courts, give police and municipalities enhanced legislative powers to 'dismantle' homeless encampments. *Toronto Star*. https://www.thestar.com/politics/provincial/doug-ford-preparing-to-override-courts-give-police-and-municipalities-enhanced-legislative-powers-to-dismantle/article_5b453bf0-b316-11ef-8098-0f2b2652ce96.html

Benzie, R. (2024b, August 21, 2024). Doug Ford says safe injection sites are a 'failed policy' that harms communities and people with addictions. *Toronto Star*.

Benzie, R., & Ferguson, R. (2024, Dec 12, 2024). Doug Ford to crack down on homeless encampments with fines for drug use and more funding. *Toronto Star*. https://www.thestar.com/politics/provincial/doug-ford-to-crack-down-on-homeless-encampments-with-fines-for-drug-use-and-more/article_632d90ca-b7cf-11ef-b74a-53a89e486a7f.html

Berendonk, C., Blix, B. H., Hoben, M., Clandinin, D. J., Roach, P. M., Compton, R. M., Cave, M. T., & Caine, V. (2020). A narrative care approach for persons living with dementia in institutional care settings. *International Journal of Older People Nursing*, *15*(1). https://doi.org/10.1111/opn.12278

Berendonk, C., Blix, B. H., Randall, W. L., Baldwin, C., & Caine, V. (2017). Care as narrative practice in the context of long-term care: Theoretical considerations. *International Journal of Older People Nursing*, *12*(4), 1-9. https://doi.org/10.1111/opn.12156

Bergum, V., & Dossetor, J. B. (2005). *Relational ethics: The full meaning of respect*. University Publishing Group, Hagerstown, MD.

Best, O., & Stuart, L. (2014). An Aboriginal nurse-led working model for success in graduating Indigenous Australian nurses. *Contemporary Nurse*, *48*(1), 59-66.

Bezgrebelna, M., Hajat, S., Njenga, S., Settembrino, M. R., Vickery, J., & Kidd, S. A. (2024). Neoliberalism, climate change, and displaced and homeless populations: Exploring interactions through case studies. *Humanity & Society*, *48*(2-4), 107-129.

Bezgrebelna, M., McKenzie, K., Wells, S., Ravindran, A., Kral, M., Christensen, J., Stergiopoulos, V., Gaetz, S., & Kidd, S. A. (2021). Climate change, weather, housing precarity, and homelessness: A systematic review of reviews. *International Journal of Environmental Research and Public Health*, *18*(11), 5812.

Birrell, P. J., & Freyd, J. J. (2006). Betrayal trauma: Relational models of harm and healing. *Journal of Trauma Practice*, *5*(1), 49-63.

Blackstock, C. (2019). Indigenous child welfare legislation: A historical change or another paper tiger? *First Peoples Child & Family Review*, *14*(1), 5-8.

Blix, B. H., Berendonk, C., & Caine, V. (2019). Theoretical foundations of narrative care: Turning towards relational ethics. *Nursing Ethics*, *26*(7-8), 1917-1927.

Blix, B. H., Berendonk, C., Clandinin, D. J., & Caine, V. (2021). The necessity and possibilities of playfulness in narrative care with older adults. *Nursing Inquiry*, *28*(1), 1-8. https://doi.org/10.1111/nin.12373

Blumer, H. (1969). *Symbolic interactionism* (Vol. 9). Prentice-Hall.

Bodnaresko, S. (2024). *Reciprocal citizenship: settling into the responsibilities of living on Indigenous lands* [Doctoral Dissertation, University of Calgary]. Calgary, Canada.

Boley, S., Sidebottom, A., Vacquier, M., Watson, D., Van Eyll, B., Friedman, S., & Friedman, S. (2024). Racial differences in stigmatizing and positive language in emergency medicine notes. *Journal of Racial and Ethnic Health Disparities*, 1-11.

Bombay, A., Matheson, K., & Anisman, H. (2011). The impact of stressors on second generation Indian Residential School survivors. *Transcultural psychiatry*, *48*(4), 367-391.

Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historical trauma. *Transcultural psychiatry*, *51*(3), 320-338.

Bonilla-Silva, E. (1994). Rethinking racism: Towards a structural interpretation. In University of Michigan (Ed.), *Center for research on social organization working paper series*.

Bonilla-Silva, E. (2021). What makes systemic racism systemic? *Sociological Inquiry*, *91*(3), 513-533.

Bonilla-Silva, E. (2023). It's not the rotten apples! Why family scholars should adopt a structural perspective on racism. *Journal of Family Theory & Review*, *15*(2), 192-205.

Bono, K. (2019). *The faces of Indigenous homelessness: The perpetual Inuit housing struggle* [Masters Thesis, McGill University]. https://escholarship.mcgill.ca/concern/papers/4t64gs73n

Botelho, M. J., & Lima, C. A. (2020). From cultural competence to cultural respect: A critical review of six models. *Journal of Nursing Education*, *59*(6), 311-318.

Bourque Bearskin, L. (2011). A critical lens on culture in nursing practice. *Nursing Ethics*, *18*(4), 548-559.

Bourque Bearskin, L. (2014). *Mâmawoh Kamâtowin: Coming together to help each other: Honouring Indigenous nursing knowledge.* [Doctoral Dissertation, University of Alberta]. Education & Research Archive. https://era.library.ualberta.ca/items003498c2-58a6-4a75-9ede-881befa0bcc7

Bourque Bearskin, L. (2023). Decolonization the what, why and how: A treaties on Indigenous nursing knowledge.

Bourque Bearskin, L., Kennedy, A., & Joseph, C. (2020). Bearing witness to Indigenous health nursing. *Witness: The Canadian Journal of Critical Nursing Discourse*, *2*(1), 1-8.

Bourque Bearskin, L., Seymour, M. s. L. C., Melnyk, R., D'Souza, M., Sturm, J., Mooney, T., Hunter-Porter, N. R., Ward, A. E., & Bell, B. (2025). Truth to action: Lived experiences of Indigenous healthcare professionals redressing Indigenous-specific racism. *Canadian Journal of Nursing Research*, *57*(1), 94-111.

Box, E., Flatau, P., & Lester, L. (2022). Women sleeping rough: The health, social and economic costs of homelessness. *Health & Social Care in the Community*, *30*(6), e4175-e4190.

Boyd, J., Collins, A. B., Mayer, S., Maher, L., Kerr, T., & McNeil, R. (2018). Gendered violence and overdose prevention sites: A rapid ethnographic study during an overdose epidemic in Vancouver, Canada. *Addiction*, *113*(12), 2261-2270.

Boyer, Y., & Leggett, R. (2022). Forced sterilization: A malicious determinant of health. *Introduction to Determinants of First Nations, Inuit, and Métis Peoples' Health in Canada*, 37-50.

Braimoh, J., Dej, E., & Sanders, C. (2023). "Somebody's street": Eviction of homeless encampments as a reflection of interlocking colonial and class relations. *Journal of Law and Social Policy*, *36*, 12.

Brascoupé, S., & Waters, C. (2009). Cultural safety exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *International Journal of Indigenous Health*, *5*(2), 6-41.

Brayboy, B. M. J. (2005). Toward a tribal critical race theory in education. *The urban review*, *37*, 425-446.

British Columbia College of Nurses and Midwives. (2022). *Indigenous cultural safety and humility practice standard*. https://www.bccnm.ca/Documents/cultural_safety_humility/All_PS_cultural_safety_humility.pdf

Brockie, T., Clark, T. C., Best, O., Power, T., Bourque Bearskin, L., Kurtz, D. L., Lowe, J., & Wilson, D. (2023). Indigenous social exclusion to inclusion: Case studies on Indigenous nursing leadership in four high income countries. *Journal of Clinical Nursing*, *32*(3-4), 610-624.

Brockman, M. (2016). Exploring the roots of prejudice toward Aboriginal Peoples in Canada. *The Canadian Journal of Native Studies*, *36*(2), 13.

Brookes, G., & Nuku, K. (2020). Why we aren't celebrating Florence's birthday. *Kai Tiaki: Nursing New Zealand*, *26*(3), 34-35.

Browne, A., & Smye, V. (2002). A post-colonial analysis of healthcare discourses addressing Aboriginal women. *Nurse Researcher*, *9*(3), 1-28.

Browne, A., Varcoe, C., & Fridkin, A. (2011). Addressing trauma, violence, and pain: research on health services for women at the intersections of history and economics. In O. Hankivsky, J. de Leeuw, B. Lee, & N. Vissandjée (Eds.), *Health inequities in Canada: Intersectional frameworks and practices* (pp. 295-311). University of British Colombia Press.

Browne, A., Varcoe, C., Lavoie, J., Smye, V., Wong, S., Krause, M., Tu, D., Godwin, O., Khan, K., & Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Services Research*, *16*(1), 544.

Browne, A. J. (2017). Moving beyond description: Closing the health equity gap by redressing racism impacting Indigenous populations. *Social Science & Medicine*, *184*, 23-26. https://doi.org/10.1016/j.socscimed.2017.04.045

Browne, A. J., & Reimer-Kirkham, S. (2014). Problematizing social justice discourses in nursing. In P. N. Kagan, M. C. Smith, & P. L. Chinn (Eds.), *Philosophies and practices of emancipatory nursing: Social justice as praxis* (pp. 21-38). Routledge.

Browne, A. J., & Varcoe, C. (2006). Critical cultural perspectives and health care involving Aboriginal peoples. *Contemporary Nurse*, *22*(2), 155-168.

Browne, A. J., Varcoe, C., Wytenbroek, L., De Sousa, I., & Crosschild, C. (2023). Using philosophical inquiry to dismantle dominant thinking in nursing about race and racism. In *Routledge handbook of philosophy and nursing* (pp. 379-391). Routledge.

Bryce, P. H. (1907). *Report of the Indian Schools of Manitoba and the Northwest Territories*. Retrieved from https://publications.gc.ca/collections/collection_2018/aanc-inac/R5-681-1907-eng.pdf

Bryce, P. H. (1922). *The story of a national crime: An appeal for justice to the Indians of Canada*. James Hope and Sons Limited.

Bryder, L. (2018). 'They do what you wish; they like you; you the good nurse!': Colonialism and Native health nursing in New Zealand, 1900–40. In *Colonial caring* (pp. 84-103). Manchester University Press.

Bucharski, D., Reutter, L. I., & Ogilvie, L. D. (2006). "You need to know where we're coming from": Canadian Aboriginal women's perspectives on culturally appropriate HIV counseling and testing. *Health Care for Women International*, *27*(8), 723-747. https://doi.org/10.1080/07399330600817808

Budd, B. (2024). *News framing of Indigenous politics in Canada: Representation in the era of reconciliation*. Palgrave Macmillan. https://doi.org/10.1007/978-3-031-64758-1_3

Burnett, K. (2010). *Taking Medicine: Women's Healing Work and Colonial Contact in Southern Alberta, 1880-1930*. UBC Press.

Butler, J. (2009). *Giving an account of oneself*. Fordham University Press.

Butler, J. (2016). *Frames of war: When is life grievable?* Verso Books.

Byrne, T. H., Henwood, B. F., & Orlando, A. W. (2021). A rising tide drowns unstable boats: How inequality creates homelessness. *The ANNALS of the American Academy of Political and Social Science*, *693*(1), 28-45.

Came, H., & Griffith, D. (2018). Tackling racism as a "wicked" public health problem: enabling allies in anti-racism praxis. *Social Science & Medicine*, *199*, 181-188.

Came, H., & Humphries, M. (2020). Mopping up institutional racism: activism on a napkin. In *Storytelling: Beyond the Academic Article–Using Fiction, Art and Literary Techniques to Communicate* (pp. 95-108). Routledge.

Campbell, R. A. (2008). Making sober citizens: The legacy of Indigenous alcohol regulation in Canada, 1777-1985. *Journal of Canadian Studies*, *42*(1), 105-126.

Campinha-Bacote, J. (2011). Coming to know cultural competence: An evolutionary process. *International Journal of Human Caring*, *15*(3), 42-48.

Campinha-Bacote, J. (2019). Cultural competemility: A paradigm shift in the cultural competence versus cultural humility debate—Part I. *Online Journal of Issues in Nursing*, *24*(1).

Canadian Charter of Rights and Freedoms, (1982).

Canadian Council of Registered Nurse Regulators. (2012). *Competencies in the context of entry-level registered nurse practice: A report of the 2011-12 jurisdictional competency process: Entry-level registered nurses*. https://www.ccrnr.ca/assets/jcp_rn_competencies_2012_edition.pdf

Canadian Council of Registered Nurse Regulators. (2018). *Entry-level competencies (ELCs) for the practice of registered nurses*. https://www.ccrnr.ca/assets/ccrnr-rn-entry-level-competencies---2019.pdf

Canadian Human Rights Act, R.S.C., 1985, c. H-6, (1985). https://laws-lois.justice.gc.ca/eng/acts/h-6/page-1.html

Canadian Indigenous Nurses Association. (2016). The Indigenous nurse: Celebrating 40 years. In.

Canadian Nurses Association. (2010). *Social justice a means to an end an end in itself*. https://nccdh.ca/resources/entry/social-justice...-a-means-to-an-end-an-end-in-itself

Canadian Nurses Association. (2017). *Code of ethics for registered nurses*. cna-aiic.ca/ethics

Canadian Nurses Association. (2018). *Position statement: Promoting cultural competence in nursing*. https://www.cna-aiic.ca/en/policy-advocacy/policy-support-tools/position-statements

Canadian Nurses Association. (2021a). *Nursing declaration against anti-Black racism in nursing and health care*. https://www.cna-aiic.ca/en/policy-advocacy/advocacy-priorities/racism-in-health-care

Canadian Nurses Association. (2021b). *Nursing declaration against anti-Indigenous racism in nursing and health care*. https://www.cna-aiic.ca/en/policy-advocacy/advocacy-priorities/indigenous-health

Canham, S. L., Weldrick, R., Erisman, M., McNamara, A., Rose, J. N., Siantz, E., Casucci, T., & McFarland, M. M. (2024). A scoping review of the experiences and outcomes of stigma and discrimination towards persons experiencing homelessness. *Health & Social Care in the Community*, *2024*(1), 2060619.

Canty, L., Nyirati, C., Taylor, V., & Chinn, P. L. (2022). An overdue reckoning on racism in nursing. *AJN The American Journal of Nursing*, *122*(2), 26-34.

Carey, M. (2015). The limits of cultural competence: An Indigenous studies perspective. *Higher Education Research & Development*, *34*(5), 828-840.

CBC News. (2015). Brian Sinclair inquest recommendations slammed by ER doctors: Canadian Association of Emergency Physicians says report misses key point about ER overcrowding. *CBC News,*. https://www.cbc.ca/news/canada/manitoba/brian-sinclair-inquest-recommendations-slammed-by-er-doctors-1.3003302

CBC News. (n.d., June 8, 2022). *Beyond 94 truth and reconcilliation in Canada*. Retrieved January 12 from https://www.cbc.ca/newsinteractives/beyond-94/

Challand, A. (2023). A Critical discourse analysis of Indigenous homelessness: On social problems and silences in Alberta news media. *The Motley Undergraduate Journal*, *1*(2).

Chan, V., Estrella, M. J., Hanafy, S., Colclough, Z., Joyce, J. M., Babineau, J., & Colantonio, A. (2023). Equity considerations in clinical practice guidelines for traumatic brain injury and homelessness: A systematic review. *EClinicalMedicine*, *63*.

Chang, J. S., Riley, P. B., Aguirre, R. J., Lin, K., Corwin, M., Nelson, N., & Rodriguez, M. (2022). Harms of encampment abatements on the health of unhoused people. *SSM-qualitative research in health*, *2*, 100064.

Charmaz, K. (2017). Constructivist grounded theory. *The Journal of Positive Psychology*, *12*(3), 299. https://doi.org/10.1080/17439760.2016.1262612

CHCH News. (2024, Sept 23, 2024). *'Get off your A-S-S and start working': Doug Ford's advice to the unhoused*. https://www.youtube.com/watch?v=tt6GKFMsX6o

Cheekireddy, M., Madampage, C., Hammond, C., Chelico, L., & King, A. (2022). *Environmental scan of HIV and Hepatitis C programs, projects and initiatives, Saskatchewan*. Canada Communicable Disease Report

Chilisa, B. (2012). Postcolonial Indigenous research paradigms. In *Indigenous research methodologies* (pp. 98-127). Sage Publications.

Chiu, P., Cummings, G. G., Thorne, S., & Schick-Makaroff, K. (2021). Policy advocacy and nursing organizations: A scoping review. *Policy, Politics, & Nursing Practice*, *22*(4), 276-296.

Christianson, T. (2024). *The impact of COVID-19 on services for Indigenous people who use substances and are living with HIV in Winnipeg, Manitoba* [Masters Thesis, University of Manatoba].

Cidro, J., Bach, R., & Frohlick, S. (2020). Canada's forced birth travel: Towards feminist Indigenous reproductive mobilities. *Mobilities*, *15*(2), 173-187.

City of Ottawa. (2018). *Everyone counts: Ottawa's 2018 point-in-time count*. https://documents.ottawa.ca/sites/documents/files/Point%20in%20Time%20Report%20EN_0.pdf

City of Ottawa. (2021). *2021 Homelessness point-in-time count: 24 hours in October*. https://documents.ottawa.ca/sites/documents/files/PointInTime_Infographic_EN_.pdf

Clarke, A. E., Friese, C., & Washburn, R. (2016). *Situational analysis in practice: Mapping research with grounded theory*. Routledge.

Clarke, A. E., Friese, C., & Washburn, R. S. (2017). *Situational analysis: Grounded theory after the interpretive turn*. Sage Publications.

Clarke, A. E., & Star, S. L. (2008). The social worlds framework: A theory/methods package. *The handbook of science and technology studies*, *3*(0), 113-137.

Clarke, E. (2021). Indigenous women and the risk of reproductive healthcare: Forced sterilization, genocide, and contemporary population control. *Journal of Human Rights and Social Work*, *6*(2), 144-147.

Clifford, A., McCalman, J., Bainbridge, R., & Tsey, K. (2015). Interventions to improve cultural competency in health care for Indigenous peoples of Australia, New Zealand, Canada and the USA: A systematic review. *International Journal for Quality in Health Care*, *27*(2), 89-98.

Coburn, V. (2009). *Citizenship and colonialism in Canada* [Masters Thesis, University of Regina]. https://ourspace.uregina.ca/bitstream/handle/10294/13696/MR55095.pdf?sequence=1

Colledge-Frisby, S., Ottaviano, S., Webb, P., Grebely, J., Wheeler, A., Cunningham, E. B., Hajarizadeh, B., Leung, J., Peacock, A., & Vickerman, P. (2023). Global coverage of interventions to prevent and manage drug-related harms among people who inject drugs: A systematic review. *The Lancet Global Health*, *11*(5), e673-e683.

Collier-Sewell, F. (2023). Attending to our conceptualisations of race and racism in the pursuit of antiracism: A critical interpretative synthesis of the nursing literature. *Nursing Inquiry*, *30*(2), e12522.

Controlled Drugs and Substances Act S.C. 1996, c. 19, (1996). https://laws-lois.justice.gc.ca/eng/acts/c-38.8/page-1.html#h-94341

Cooper, A. J. (1892/1988). *A voice from the south*. Oxford University Press.

Cooper, E., & Driedger, S. (2018). Working with unbounded communities: A Métis case study In H. Exner-Pirot, B. Norbye, & L. Butler (Eds.), *Northern and Indigenous health and health care* (pp. 55-60). University of Saskatchewan.

Cosh, C. (2024). Colby Cosh: Bill 34 suspension shows the slippery slope of B.C. harm reduction. *National Post*. https://nationalpost.com/opinion/bill-34-suspension-shows-the-slippery-slope-of-b-c-harm-reduction

Coulthard, G. S. (2007). *Subjects of empire? Indigenous Peoples and the "politics of recognition" in Canada* [Doctoral Dissertation, University of Victoria]. Victoria.

Council of the Atikamekw of Manawan, & Council de la Nation Atikamekw. (2020). *Joyce's Principle*. https://principedejoyce.com/sn_uploads/principe/Joyce_s_Principle_brief___Eng.pdf

Craft, A., & Lebihan, A. (2021). *The Treaty right to health: A sacred obligation*. N. C. C. f. I. Health. https://www.nccih.ca/Publications/Lists/Publications/Attachments/10361/Treaty-Right-to-Health_EN_Web_2021-02-02.pdf

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*(6), 1241-1299. https://doi.org/10.2307/1229039

Cross, T. (2017). *Anti-oppressive practice in harm reduction* [Master's Thesis, Ryerson University].

Culbert, I., & Brender, N. (2024). Partial truths from politicians won't fix the toxic drug crisis. *The Hill Times*. https://www.cpha.ca/partial-truths-politicians-wont-fix-toxic-drug-crisis

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 1-17.

Dailey, S. F., Talleyrand, R. M., & Goodman, R. D. (2024). Ethno-racial inequities of the COVID-19 pandemic: Implications and recommendations for mental health professionals. *International Journal for the Advancement of Counselling*, *46*(2), 441-463.

Daniels, C., Aluso, A., Burke-Shyne, N., Koram, K., Rajagopalan, S., Robinson, I., Shelly, S., Shirley-Beavan, S., & Tandon, T. (2021). Decolonizing drug policy. *Harm reduction journal*, *18*(1), 120.

Daschuk, J. W. (2013). *Clearing the plains: Disease, politics of starvation, and the loss of Aboriginal life*. University of Regina Press.

Davis, A. Y. (1983). *Women, race & class*. Vintage.

Davison, C. M., Ford, C. S., Peters, P. A., & Hawe, P. (2011). Community-driven alcohol policy in Canada's northern territories 1970–2008. *Health Policy*, *102*(1), 34-40.

De Shalit, A., Van der Meulen, E., Chu, S. K. H., & Thomas, R. (2024). Drug use stigma and reprisal: Barriers to prison needle exchange in Canada. *The Prison Journal*, *104*(3), 344-364.

Dekker, L. (2016). Cultural safety and critical race theory: Education frameworks to promote reflective nursing practice. In R. Sawyer, J. Norris, & H. Brown (Eds.), *Forms of Practitioner Reflexivity: Critical, conversational, and arts-based approaches* (pp. 91-115). Springer.

Denison, J., Varcoe, C., & Browne, A. (2014). Aboriginal women's experiences of accessing health care when state apprehension of children is being threatened. *Journal of Advanced Nursing*, *70*(5), 1105-1116. https://doi.org/10.1111/jan.12271

Denley, R. (2024). Hiding from Ontario's nursing shortage won't save Doug Ford from its consequences. *National Post*. https://nationalpost.com/opinion/randall-denley-hiding-from-nursing-shortage-wont-save-ford-from-consequences

Dertadian, G. C., & Rance, J. (2023). Lives worth grieving: Differential coverage of overdose deaths in Australian news media (2015–2020). *Contemporary Drug Problems*, *50*(3), 361-380.

Deschenes, S., & Kunyk, D. (2020). Situating moral distress within relational ethics. *Nursing Ethics*, *27*(3), 767-777.

DiAngelo, R. (2018). *White fragility: Why it's so hard for White people to talk about racism*. Beacon Press.

Dillard-Wright, J. (2022). A radical imagination for nursing: Generative insurrection, creative resistance. *Nursing Philosophy*, *23*(1), e12371.

Dion Stout, M. (2012). Ascribed health and wellness, Atikowisi miýw-āyāwin, to achieved health and wellness, Kaskitamasowin miýw-āyāwin: Shifting the paradigm. *CJNR (Canadian Journal of Nursing Research)*, *44*(2), 11-14.

Dion Stout, M., Wieman, C. N., Bearskin, L. B., Palmer, B. C., Brown, L., Brown, M., & Marsden, N. (2021). Gum yan asing Kaangas giidaay han hll guudang gas ga. I will never again feel that I am less than: Indigenous health care providers' perspectives on ending racism in health care. *International Journal of Indigenous Health*, *16*(1).

Doane, G. H., & Varcoe, C. (2007). Relational practice and nursing obligations. *Advances in Nursing Science*, *30*(3), 192-205.

Downey, B. (2014). *Diaspora Health Literacy: reclaiming and restoring Nibwaakaawin (wisdom) and mending broken hearts*

Downey, B. (2020). Completing the circle: Towards the achievement of IND-equity-A culturally relevant health equity model by/for Indigenous populations. *Witness: The Canadian Journal of Critical Nursing Discourse*, *2*(1), 97-110.

Draaisma, M. (2023, June 28, 2023). City of Barrie backs down on plan to ban giving food to homeless people on its property. *CBC News*. https://www.cbc.ca/news/canada/toronto/barrie-homelessness-bylaws-ban-meeting-1.6884615

Drees, L. M. (2013). Healing histories: Stories from Canada's Indian hospitals. In *Healing Histories*. University of Alberta Press.

Dua, E., Razack, N., & Warner, J. N. (2005). Race, racism, and empire: Reflections on Canada. *Social Justice*, *32*(4 (102), 1-10.

Eaker, M. (2021). Wâhkôtowin: A Nehiyaw ethical analysis of anti-Indigenous racism in Canadian nursing. *Witness: The Canadian Journal of Critical Nursing Discourse*, *3*(1), 31-44.

Elliott, J., Stuart, M., & Toman, C. (2009). *Place and practice in Canadian nursing history*. UBC Press.

Ermine, W. (2007). The ethical space of engagement. *Indigenous Law Journal*, *6*(1), 193-203.

Etowa, J., & Hyman, I. (2022). Leadership and system transformation: Advancing the role of community health nursing. *Witness: The Canadian Journal of Critical Nursing Discourse*, *4*(2), 5-16.

Fanon, F. (2007). *The wretched of the earth*. Grove/Atlantic, Inc.

Felman, S., & Laub, D. (1992). *Testimony: Crises of witnessing in literature, psychoanalysis, and history*. Taylor & Francis.

Ferrazzi, P., Christie, P., Jalovcic, D., Tagalik, S., & Grogan, A. (2018). Reciprocal Inuit and Western research training: Facilitating research capacity and community agency in Arctic research partnerships. *International Journal of Circumpolar Health*, *77*(1), 1425581.

Ferrazzi, P., Tagalik, S., Christie, P., Karetak, J., Baker, K., & Angalik, L. (2019). Aajiiqatigiingniq: an Inuit consensus methodology in qualitative health research. *International Journal of Qualitative Methods*, *18*, 1-9. https://doi.org/10.1177/1609406919894796

First Nations Health Authority. (2020). *Paddling together: Report on recommendations for trauma informed and culturally safe emergency care*. https://www.fnha.ca/Documents/FNHA-Paddling-Together-Report.pdf

First Nations Health Authority. (n.d.). *Policy statement cultural safety and cultural humility*. https://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf

First Nations Information Governance Centre. (2014). *Ownership, Control, Access and Possession (OCAP™): The path to First Nations information governance.* https://achh.ca/wp-content/uploads/2018/07/OCAP_FNIGC.pdf

Flaherty, M. (1995). Freedom of expression or freedom of exploitation. *Northern Review*(14), 178–185.

Foreman-Mackey, A., Bayoumi, A. M., Miskovic, M., Kolla, G., & Strike, C. (2019). 'It's our safe sanctuary': Experiences of using an unsanctioned overdose prevention site in Toronto, Ontario. *International Journal of Drug Policy*, *73*, 135-140.

Fosket, J. (2002). *Breast cancer risk and the politics of prevention: Analysis of a clinical trial,* [Doctoral Dissertation, University of California San Fransisco, and University of California Berkeley]. California.

Fowle, M. Z. (2022). Racialized homelessness: A review of historical and contemporary causes of racial disparities in homelessness. *Housing Policy Debate*, *32*(6), 940-967.

Frankenberg, R. A. E. (1988). *White women, race matters: The social construction of whiteness*. University of Minnesota Press.

Fraser, J. (2022a). *Earth dance and fire song: A journey towards transformative reconciliation in nursing education* [Doctoral Dissertation, Simon Fraser University]. https://summit.sfu.ca/_flysystem/fedora/2022-08/input_data/21797/etd21789.pdf

Fraser, J. (2022b). Relational accountability: a path towards transformative reconciliation in nursing education. *Quality Advancement in Nursing Education-Avancées en formation infirmière*, *8*(3), 8.

Fraser, S., Farrugia, A., & Dwyer, R. (2018). Grievable lives? Death by opioid overdose in Australian newspaper coverage. *International Journal of Drug Policy*, *59*, 28-35.

Freire, P. (1971). *Pedagogy of the oppressed. (M. B. Ramos, Trans.)*. Herder and Herder.

Gadow, S. (1999). Relational narrative: The postmodern turn in nursing ethics. *Scholarly Inquiry for Nursing Practice*, *13*(1), 57-70.

Gagnon, M., & Perron, A. (2020a). Nursing voices during COVID-19: An analysis of Canadian media coverage. *Aporia*, *12*(1), 109-113.

Gagnon, M., & Perron, A. (2020b). Whistleblowing: A concept analysis. *Nursing & Health Sciences*, *22*(2), 381-389.

Galan-Lominchar, M., Muñoz-San Roque, I., del Campo Cazallas, C., Mcalpin, R., Fernández-Ayuso, D., & Ribeiro, A. S. (2024). Nursing students' internationalization: Virtual exchange and clinical simulation impact cultural intelligence. *Nursing Outlook*, *72*(2), 102137.

Garneau, A. B., & Pepin, J. (2015). Cultural competence: A constructivist definition. *Journal of Transcultural Nursing*, *26*(1), 9-15.

Gebhard, A., McLean, S., & Denis, V. S. (2022). *White benevolence: Racism and colonial violence in the helping professions*. Fernwood Publishing.

Genosko, G., & Thompson, S. (2006). Administrative surveillance of alcohol consumption in Ontario, Canada: Pre electronic technologies of control. *Surveillance & Society*, *4*(1/2).

Georges, J. (2004). The politics of suffering: Implications for nursing science. *Advances in Nursing Science*, *27*(4), 250-256.

Gilchrist, K. (2010). "Newsworthy" victims? Exploring differences in Canadian local press coverage of missing/murdered Aboriginal and White women. *Feminist media studies*, *10*(4), 373-390.

Gill, J., & Baker, C. (2021). The power of mass media and feminism in the evolution of nursing's image: A critical review of the literature and implications for nursing practice. *Journal of Medical Humanities*, *42*(3), 371-386.

Gilmore, L. (2017). *Tainted witness: Why we doubt what women say about their lives*. Columbia University Press.

Ginwright, S. (2016). *Hope and healing in urban education: How urban activists and teachers are reclaiming matters of the heart*. Routledge.

Ginwright, S. (2018). The future of healing: Shifting from trauma informed care to healing centered engagement. *Medium*. https://ginwright.medium.com/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c

Godkhindi, P., Nussey, L., & O'Shea, T. (2022). "They're causing more harm than good": A qualitative study exploring racism in harm reduction through the experiences of racialized people who use drugs. *Harm reduction journal*, *19*(1), 96.

Goerdat, A. (2024). *The relation between cold weather conditions and health damage in people sleeping rough* [Masters Thesis, University of Utrecht, Netherlands].

González, H., Errasti-Ibarrondo, B., Iraizoz-Iraizoz, A., & Choperena, A. (2023). The image of nursing in the media: A scoping review. *International Nursing Review*, *70*(3), 425-443.

Goodman, A., Fleming, K., Markwick, N., Morrison, T., Lagimodiere, L., & Kerr, T. (2017). "They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal Peoples living in Vancouver's inner city. *Social Science & Medicine*, *178*, 87-94. https://doi.org/10.1016/j.socscimed.2017.01.053

Goodyear, T. (2021). (Re) politicizing harm reduction: Poststructuralist thinking to challenge the medicalization of harms among people who use drugs. *Aporia*, *13*(1).

Gottlieb, L. N. (2010). Lynn McDonald: Champion of Florence Nightingale. *Canadian Journal of Nursing Research Archive*, 3-10.

Government of British Columbia. (2020). *In plain sight: Addressing Indigenous specific racism and discrimination in B.C. health care, addressing racism review: Summary report, November 2020*. Government of British Columbia. https://engage.gov.bc.ca/addressingracism/

Government of Canada. (2023). *Everyone counts 2020-2022 – results from the third nationally coordinated point-in-time counts of homelessness in Canada*. Retrieved from

https://www.infrastructure.gc.ca/homelessness-sans-abri/reports-rapports/pit-counts-dp-2020-2022-results-resultats-eng.html#toc_6.13

Government of Canada. (2024). *Implementing the United Nations Declaration on the Rights of Indigenous Peoples Act*. Ottawa, Canada Retrieved from https://www.justice.gc.ca/eng/declaration/index.html

Government of Ontario. (2021). *Protection services for 16 and 17 year olds*. Retrieved from https:www.ontario.ca/files/2022-04/mccss-information-for-you-serving-agencies-en-2022-04.pdf

Government of Ontario. (2024). *News release: Ontario protecting communities and supporting addiction recovery with new treatment hubs* https://news.ontario.ca/en/release/1004955/ontario-protecting-communities-and-supporting-addiction-recovery-with-new-treatment-hubs

Gozu, A., Beach, M. C., Price, E. G., Gary, T. L., Robinson, K., Palacio, A., Smarth, C., Jenckes, M., Feuerstein, C., & Bass, E. B. (2007). Self-administered instruments to measure cultural competence of health professionals: A systematic review. *Teaching and learning in medicine*, *19*(2), 180-190.

Graham, S., Muir, N. M., Formsma, J. W., & Smylie, J. (2023). First Nations, Inuit and Métis Peoples living in urban areas of Canada and their access to healthcare: A systematic review. *International Journal of Environmental Research and Public Health*, *20*(11), 5956.

Green, J. (Ed.). (2017). *Making space for Indigenous feminism, 2nd Edition*. Fernwood Publishing.

Green, M. (2024). Privileged observers and colonial continuities: Institutional economies of expert knowledge in anthropology and international development. *American Ethnologist*, *51*(1), 118-125.

Greer, A. M., Luchenski, S. A., Amlani, A. A., Lacroix, K., Burmeister, C., & Buxton, J. A. (2016). Peer engagement in harm reduction strategies and services: A critical case study and evaluation framework from British Columbia, Canada. *BMC Public Health*, *16*, 1-9.

Greto, T. (2023). *Ignored inequities: The case of British Columbia's "Stop Overdose" anti-stigma campaign* [Masters Thesis, Brock University]. St. Catharines, Ontario.

Greto, T., & Neufeld, S. D. (2024). Ignored inequities: Critical analysis of the pre-launch development of British Columbia's "Stop Overdose" campaign. *International Journal of Drug Policy*, *131*, 104546.

Grey, S., & James, A. (2016). Truth, reconciliation, and "double settler denial": gendering the Canada-South Africa analogy. *Human Rights Review*, *17*(3), 303-328. https://doi.org/10.1007/s12142-016-0412-8

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In *Handbook of qualitative research* (Vol. 2, pp. 105). Sage.

Guirguis-Younger, M., McNeil, R., & Hwang, S. (Eds.). (2014). *Homelessness and health in Canada*. University of Ottawa Press.

Gustafson, D. L. (2005). Transcultural nursing theory from a critical cultural perspective. *Advances in Nursing Science*, *28*(1), 2-16.

Haghiri-Vijeh, R. (2022). "Ally theater is a problem": LGBTQI+ migrants' experiences with nurses in Canada. *Advances in Nursing Science*, *46*(1), 75-87.

Hall, J. M., & Fields, B. (2012). Race and microaggression in nursing knowledge development. *Advances in Nursing Science*, *35*(1), 25-38.

Hall, L. J. (2022). Sweeping away survival: How anti-homeless laws & practices infringe on the fundamental right to survive. *Loyola Journal of Public Interest Law*, *24*(2), 1-30.

Hall, W., Stjepanović, D., Dawson, D., & Leung, J. (2023). The implementation and public health impacts of cannabis legalization in Canada: A systematic review. *Addiction*, *118*(11), 2062-2072.

Hamm, A. (2024, Oct 18, 2024). Amy Hamm: Blame 'progressives' for Canada's hellish homeless encampments. *The National Post*. https://nationalpost.com/opinion/blame-progressives-for-canadas-hellish-homeless-encampments

Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health*, *18*(3), 271-283. https://doi.org/10.1080/09581590802294296

Hanoa, K., Bilgrei, O. R., & Buvik, K. (2024). Injecting alone. The importance of perceived safety, stigma and pleasure for solitary injecting. *Journal of Drug Issues*, *54*(1), 74-89.

Hantke, S., St. Denis, V., & Graham, H. (2022). Racism and antiracism in nursing education: Confronting the problem of whiteness. *BMC nursing*, *21*(1), 146.

Haraway, D. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspective. *Feminist Studies*, *14*(3), 575-599.

Hardill, K. (2007). From the grey nuns to the streets: A critical history of outreach nursing in Canada. *Public Health Nursing*, *24*(1), 91-97.

Harry, L. (2014). *Exploring relational nursing with Canada's Aboriginal Peoples: An integrative literature review* [Masters Thesis, University of Victoria]. http://dspace.library.uvic.ca/handle/1828/5329

Hart, M. A. (2010). Indigenous worldviews, knowledge, and research: The development of an Indigenous research paradigm. *Journal of Indigenous Social Development*, *1*(1), 1-16.

Haskell, L., & Randall, M. (2009). Disrupted attachments: A social context complex trauma framework and the lives of Aboriginal Peoples in Canada. *Journal of Aboriginal Health*, *5*(3), 48-99.

Hassen, N., Lofters, A., Michael, S., Mall, A., Pinto, A. D., & Rackal, J. (2021). Implementing anti-racism interventions in healthcare settings: A scoping review. *International Journal of Environmental Research and Public Health*, *18*(6), 2993.

Havenga, Y., Temane, A., Ramukumba, T., & Nolte, A. (2018). Ethics in nursing–A South African perspective. In N. Nortjé, W. A. Hoffmann, & J.-C. De Jongh (Eds.), *African Perspectives on ethics for healthcare professionals* (pp. 175-188). Springer.

Hawkins, S., & Sweet, H. (Eds.). (2014). *Colonial caring: A history of colonial and post-colonial nursing*. Manchester University Press.

Healey, G. (2016). (Re)settlement, displacement, and family separation: contributors to health inequality in Nunavut. *Northern Review*, *1*(42), 47-68.

Healey, G., & Tagak, A. S. (2014). Piliriqatigiinniq 'working in a collaborative way for the common good': A perspective on the space where health research methodology and Inuit epistemology come together. *International Journal of Critical Indigenous Studies*, *7*(1), 1-14.

Heaslip, V., Richer, S., Simkhada, B., Dogan, H., & Green, S. (2021). Use of technology to promote health and wellbeing of people who are homeless: A systematic review. *International Journal of Environmental Research and Public Health*, *18*(13), 6845.

Heft, H. (2017). Perceptual information of “an entirely different order”: The “cultural environment” in the senses considered as perceptual systems. *Ecological Psychology*, *29*(2), 122-145.

Heller, J. C., Givens, M. L., Johnson, S. P., & Kindig, D. A. (2024). Keeping it political and powerful: Defining the structural determinants of health. *The Milbank Quarterly*, *102*(2), 351-366.

Herman, J. L., & van der Kolk, B. A. (2020). *Treating complex traumatic stress disorders in adults: Scientific foundations and therapeutic models*. Guilford Publications.

Hess, J. D. (2001). *The relational narrative: A postmodern ethic for nursing* [Doctoral Dissertation, University of Colorado].

Hill, K., Dunham, K., Doneski, K., Sue, K. L., Thakarar, K., & Butner, J. (2024). In Support of the Decriminalization of Personal Drug and Paraphernalia Use and Possession: Position Statement of AMERSA, Inc (Association for Multidisciplinary Education, Research, Substance Use and Addiction). *Substance Use & Addiction Journal*, *46*(1), 4-12.

Hodgetts, D., Rua, M., Groot, S., Hopner, V., Drew, N., King, P., & Blake, D. (2021). Relational ethics meets principled practice in community research engagements to understand and address homelessness. *Journal of Community Psychology*, *50*(4), 1-13. https://doi.org/10.1002/jcop.22586

hooks, B. (1981). *Ain't I a Woman?: Black women and feminism.* South End Press.

hooks, B. (2000). *Feminist theory: From margin to center*. Pluto Press.

Hopper, E., Bassuk, E., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The open health services and policy journal*, *3*(1).

Horrill, T. C. (2021). *Access to oncology care among Indigenous Peoples and the role of nurses* [Doctoral Dissertation, University of Manitoba].

Horrill, T. C., Linton, J., Lavoie, J. G., Martin, D., Wiens, A., & Schultz, A. S. (2019). Access to cancer care among Indigenous Peoples in Canada: A scoping review. *Social Science & Medicine*, *238*(112495).

Horrill, T. C., Martin, D. E., Lavoie, J. G., & Schultz, A. S. (2022). Access denied: Nurses' perspectives of access to oncology care among Indigenous Peoples in Canada. *Advances in Nursing Science*, *45*(4), 292-308.

Harm Reduction Nurses Association v. British Columbia (Supreme Court of British Columbia December 29, 2023), (2023). https://www.bccourts.ca/jdb-txt/sc/23/22/2023BCSC2290.htm

Hunter, K., & Cook, C. (2020). Indigenous nurses’ practice realities of cultural safety and socioethical nursing. *Nursing Ethics*, *27*(6), 1472-1483.

Hurley, E. S. (2024). The next seven generations: at the heart of care alongside Mi’kmaw women. *AlterNative: An International Journal of Indigenous Peoples*, *20*(1), 189-193.

Huston, G. (2024, February 19, 2024). Drug-paraphernalia debris in Ottawa. ‘A parent's worst nightmare'. *The Ottawa Citizen*. https://ottawacitizen.com/news/local-news/drug-paraphernalia-debris-in-ottawa-a-parents-worst-nightmare

Hwang, S. W., Colantonio, A., Chiu, S., Tolomiczenko, G., Kiss, A., Cowan, L., Redelmeier, D. A., & Levinson, W. (2008). The effect of traumatic brain injury on the health of homeless people. *CMAJ*, *179*(8), 779-784.

Hyshka, E., Anderson-Baron, J., Karekezi, K., Belle-Isle, L., Elliott, R., Pauly, B., Strike, C., Asbridge, M., Dell, C., & McBride, K. (2017). Harm reduction in name, but not

substance: A comparative analysis of current Canadian provincial and territorial policy frameworks. *Harm reduction journal*, *14*, 1-14.

Iheduru-Anderson, K., Shingles, R. R., & Akanegbu, C. (2021). Discourse of race and racism in nursing: An integrative review of literature. *Public Health Nursing*, *38*(1), 115-130.

International Council of Nurses. (2021). *The ICN code of ethics for nurses*. https://www.icn.ch/sites/default/files/2023-06/ICN_Code-of-Ethics_EN_Web.pdf

Inuit Tapiriit Kanatami. (2018). *National Inuit strategy on research*. https://www.itk.ca/wp-content/uploads/2018/03/National-Inuit-Strategy-on-Research.pdf

Iverson, K. M., Dardis, C. M., Grillo, A. R., Galovski, T. E., & Pogoda, T. K. (2019). Associations between traumatic brain injury from intimate partner violence and future psychosocial health risks in women. *Comprehensive Psychiatry*, *92*, 13-21.

Jackson, D., Hickman, L. D., Hutchinson, M., Andrew, S., Smith, J., Potgieter, I., Cleary, M., & Peters, K. (2014). Whistleblowing: An integrative literature review of data-based studies involving nurses. *Contemporary Nurse*, *48*(2), 240-252.

James, A. (2001). Making sense of race and racial classification. *Race and Society*, *4*(2), 235-247.

Jennings, B. (2015). Relational liberty revisited: Membership, solidarity and a public health ethics of place. *Public Health Ethics*, *8*(1), 7-17.

Jennings, B. (2018). Solidarity and care as relational practices. *Bioethics*, *32*(9), 553-561.

Jennings, B. (2019). Relational ethics for public health: Interpreting solidarity and care. *Health Care Analysis*, *27*(1), 4-12.

Jennings, W., Bond, C., & Hill, P. S. (2018). The power of talk and power in talk: A systematic review of Indigenous narratives of culturally safe healthcare communication. *Australian Journal of Primary Health*, *24*(2), 109-115.

Jewell, E., & Mosby, I. (2022). *Calls to action accountability: A 2022 status update on reconcilliation*. Y. Institute. https://yellowheadinstitute.org/trc/

Jewell, E., & Mosby, I. (2023). *Calls to Action Acountability: A 2023 Status Update on Reconcilliation*. Y. Institute. https://yellowheadinstitute.org/trc/

Jiwani, Y. (2009). Symbolic and discursive violence in media representations of Aboriginal missing and murdered women. In M. Guggisberg & D. Weir (Eds.), *Understanding violence: Contexts and portrayals* (pp. 63-74). Inter-Disciplinary Press, Oxford.

Johnston, G. (2020). The kids are all white: Examining race and representation in news media coverage of opioid overdose deaths in Canada. *Sociological Inquiry*, *90*(1), 123-146.

Jongbloed, K., Pearce, M. E., Pooyak, S., Meng, D. Z., Thomas, V., Demerais, L., Christian, W. M., Henderson, E., Sharma, R., Blair, A. H., Yoshida, E. M., Schechter, M. T., Spittal, P. M., & Zamar, D. (2017). The Cedar Project: Mortality among young Indigenous people who use drugs in British Columbia. *CMAJ: Canadian Medical Association Journal*, *189*(44), E1352-E1359. https://doi.org/10.1503/cmaj.160778

Jongbloed, K., Pooyak, S., Pearce, M. E., Mazzuca, A., Sharma, R., Christian, W. M., Teegee, M., Demerais, L., Lester, R. T., & Schechter, M. T. (2024). The Cedar Project: Intergenerational child apprehension and HIV health and wellness among young Indigenous peoples who have used drugs: A mixed methods study. *First Nations Health and Wellbeing-The Lowitja Journal*, *2*, 100030.

Kamel, G. (2020). *Investigation report: Law on the investigation of the causes and circumstances of death for the protection of human life concerning the death of Joyce*

Echaquan 2020-00275. Governement of Quebec. https://numerique.banq.qc.ca/patrimoine/details/52327/4658465

Kaur, H., Saad, A., Magwood, O., Alkhateeb, Q., Mathew, C., Khalaf, G., & Pottie, K. (2021). Understanding the health and housing experiences of refugees and other migrant populations experiencing homelessness or vulnerable housing: A systematic review using GRADE-CERQual. *Canadian Medical Association Open Access Journal*, *9*(2), E681-E692.

Kelly, D. L. (2024). *Reclaiming Our Relationships: Exploring Students' Experience of Indigenist Antiracism Education in Nursing* University of Victoria].

Kelly, L. P., Bourque Bearskin, L., Downey, B., Perley-Dutcher, L., & Chakanyuka, C. (2023). Indigenous Nurse Perspectives: Ethical Realities. In R. Starzomski, J. L. Storch, & P. Rodney (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice (3rd. ed.)* (pp. 185). University of Victoria Libraries.

Kelly, L. P., & Chakanyuka, C. (2021). Truth before reconciliation, antiracism before cultural safety. *Contemporary Nurse*, *57*(5), 379-386.

Kelm, M.-E. (1994). *Colonizing bodies: Aboriginal health and healing in British Columbia, 1900-50* [Doctoral Dissertation, University of Toronto].

Kelsall, T. S., Veark, J., & Beatrice, M. (2025). Criminalizing public space through a decriminalization framework: The paradox of British Columbia, Canada. *International Journal of Drug Policy*, *136*, 104688.

Kendi, I. X. (2016). *Stamped from the beginning: The definitive history of racist ideas in America*. Bold Type Books.

Kendi, I. X. (2019). *How to be an antiracist*. One World: Penguin Random House

Kenny, N. P., Sherwin, S. B., & Baylis, F. E. (2010). Re-visioning public health ethics: A relational perspective. *Canadian Journal of Public Health*, *101*(1), 9-11.

Kerber, A., Donnelly, T. T., & Cruz, A. d. (2020). Harm reduction: A concept analysis. *Journal of Mental Health and Addiction Nursing*, *4*(1), e14-e25.

Kidd, I. J., & Carel, H. (2017). Epistemic injustice and illness. *Journal of applied philosophy*, *34*(2), 172-190.

Kidd, S., Greco, S., & McKenzie, K. (2021). Global climate implications for homelessness: A scoping review. *Journal of Urban Health*, *98*(3), 385-393.

Kidd, S., Thistle, J., Beaulieu, T., O'Grady, B., & Gaetz, S. (2019). A national study of Indigenous youth homelessness in Canada. *Public Health*, *176*, 163-171.

Kirkness, V. J., & Barnhardt, R. (1991). First Nations and higher education: The four R's—Respect, relevance, reciprocity, responsibility. *Journal of American Indian Education*, *30*(3), 1-15.

Kirmayer, L., Simpson, C., & Cargo, M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry*, *11*(sup1), S15-S23.

Kitching, G. T., Firestone, M., Schei, B., Wolfe, S., Bourgeois, C., O'Campo, P., Rotondi, M., Nisenbaum, R., Maddox, R., & Smylie, J. (2020). Unmet health needs and discrimination by healthcare providers among an Indigenous population in Toronto, Canada. *Canadian Journal of Public Health*, *111*(1), 40-49.

Kohm, S., & Maier, K. (2023). "The darkest time in our history": An analysis of news media constructions of liquor theft in Canada's settler colonial context. *Crime, Media, Culture*, *19*(2), 171-190.

Koptie, S. (2009). Irihapeti Ramsden: The public narrative on cultural safety. *First Peoples Child & Family Review: An Interdisciplinary Journal Honouring the Voices, Perspectives, and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews*, *4*(2), 30-43.

Koptie, S. W. (2010). Indigenous self-discovery:"Being called to witness". *First Peoples Child & Family Review*, *5*(1), 114-125.

Kovach, M. (2009). *Indigenous methodologies: Characteristics, conversations, and contexts*. University of Toronto Press.

Krik, H. (2022a). The female imperial agent and the intricacies of power: British nurses in mandate Palestine. *Journal of Middle East Women's Studies*, *18*(1), 12-35.

Krik, H. (2022b). A hospital of her own: British nurses, authority, and the colonial space in interwar Palestine and Cyprus. *Bulletin of the History of Medicine*, *96*(3), 339-374.

Kumas-Tan, Z., Beagan, B., Loppie, C., MacLeod, A., & Frank, B. (2007). Measures of cultural competence: Examining hidden assumptions. *Academic Medicine*, *82*(6), 548-557.

Kurtz, D. (2011). *Contributing to health reform: Urban Aboriginal women speak out* [Doctoral Dissertation, Deakin University]. https://hdl.handle.net/10536/DRO/DU:30040133

Kurtz, D. L., Mahara, S., Cash, P., Nyberg, J., & Moller, E. P. (2017). Indigenous methodology in understanding Indigenous nurse graduate transition to practice. *International Indigenous Policy Journal*, *8*(4), 1-17.

Kusdemir, S., & Oudshoorn, A. (2023). Nurses supporting harm reduction: How take-home naloxone is conceived in the context of neoliberalism. *Witness: The Canadian Journal of Critical Nursing Discourse*, *5*(2), 39-52.

Kweon, Y., & Choi, B. (2024). Fueling conspiracy beliefs: Political conservatism and the backlash against COVID-19 containment policies. *Governance*, *37*(3), 867-886.

Lacombe, E. (2023). Harm reduction in prisons: Restraints within the prisoners' rights discourse. *Western Journal of Legal Studies*, *14*(1). https://doi.org/10.5206/uwojls.v14i1.15144

Langager, B. (2024). Saskatchewan government halts supports for free drug materials like pipes. *Global News*. https://globalnews.ca/news/10235006/saskatchewan-government-halts-supports-for-free-drug-materials-like-pipes/

Lather, P. (2009). Against empathy, voice and authenticity. In A. Y. Jackson & L. A. Mazzei (Eds.), *Voice in qualitative inquiry: Challenging conventional, interpretive, and critical conceptions in qualitative research*. Routledge. E-book edition.

Latulippe, N. (2015). Bridging parallel rows: Epistemic difference and relational accountability in cross-cultural research. *International Indigenous Policy Journal*, *6*(2), 1-17.

Lavallée, L. F. (2009). Practical application of an Indigenous research framework and two qualitative Indigenous research methods: Sharing circles and Anishnaabe symbol-based reflection. *International Journal of Qualitative Methods*, *8*(1), 21-40.

Lawrence, B., & Dua, E. (2005). Decolonizing anti-racism. *Social Justice*, *32*(4), 120-143. http://www.jstor.org/stable/29768340

Lechasseur, K., Caux, C., Dollé, S., & Legault, A. (2018). Ethical competence: An integrative review. *Nursing Ethics*, *25*(6), 694-706.

Lee, A. (2024, Jan 30, 2024). 'Things are basically out of control': Residents voice concerns over increased crime, drug use in Carlington. *CTV News*. https://ottawa.ctvnews.ca/things-are-basically-out-of-control-residents-voice-concerns-over-increased-crime-drug-use-in-carlington-1.6748999

Lee, N. R., King, A., Vigil, D., Mullaney, D., Sanderson, P. R., Ametepee, T., & Hammitt, L. L. (2023). Infectious diseases in Indigenous populations in North America: Learning from the past to create a more equitable future. *The Lancet Infectious Diseases*, *23*(10), e431-e444.

Legislative Assembly of Ontario. *Bill 76, United Nations Declaration on the Rights of Indigenous Peoples Act, 2019* Retrieved Febuary 4, 2025 from https://www.ola.org/en/legislative-business/bills/parliament-42/session-1/bill-76

Leininger, M., & McFarland, M. (2006). *Culture care diversity and universality: A worldwide nursing theory (2nd ed.)*. Jones and Bartlett.

Lepage, M., & Flaherty, M. (2009). *Martha of the North* National Film Board (NFB). http://www.nfb.ca/film/martha_of_the_north_edu

Lightfoot, B., Panessa, C., Hayden, S., Thumath, M., Goldstone, I., & Pauly, B. (2009). Gaining Insite: Harm reduction in nursing practice. *Canadian Nurse*, *105*(4).

Loftin, C., Hartin, V., Branson, M., & Reyes, H. (2013). Measures of cultural competence in nurses: An integrative review. *The Scientific World Journal*, *1*. https://doi.org/0.1155/2013/289101

Longhurst, A., & McCann, E. (2017). Political struggles on a frontier of harm reduction drug policy: Geographies of constrained policy mobility. In S. Williams & B. Warf (Eds.), *Drugs, law, people, place and the state* (pp. 109-123). Routledge.

Loomba, A. (2015). *Colonialism/postcolonialism (3rd Edition)*. Routledge.

Lowe, J., Millender, E., & Best, O. (2022). Talking Circle For Young Adults (TC4YA) intervention: a culturally safe research exemplar. *Contemporary Nurse*, *58*(1), 95-107. https://doi.org/10.1080/10376178.2022.2080087

Luft, A. (2020). Legault sets up anti-racism task force, remains adamant systemic racism does not exist in Quebec. *CTV News*. https://montreal.ctvnews.ca/legault-sets-up-anti-racism-task-force-remains-adamant-systemic-racism-does-not-exist-in-quebec-1.4984917

Lund, A. (2024). The Edmonton encampment litigation and the Charter claims we didn't (get to) argue. *Windsor Yearbook of Access to Justice*, *40*, 229-261.

Lux, M. K. (2016). *Separate beds: a history of Indian hospitals in Canada, 1920s-1980s*. University of Toronto Press.

Lynch, J., Evans, N., Ice, E., & Costa, D. K. (2021). Ignoring nurses: Media coverage during the COVID-19 pandemic. *Annals of the American Thoracic Society*, *18*(8), 1278-1282.

MacCandless, R. A. (2013). *The missing and murdered women of Vancouver: Framing inequality in media discourse in the Vancouver Sun (2006-2011)* [Masters Thesis, Saint Mary's University].

MacDonald, H. (2007). Relational ethics and advocacy in nursing: Literature review. *Journal of Advanced Nursing*, *57*(2), 119-126.

MacDonald, S.-A., & Cote, P.-B. (2022). Navigating and negotiating health and social services in the context of homelessness: Resistance and resilience. *International Journal on Homelessness*, *2*(1), 23-36. https://doi.org/10.5206/ijoh.2022.1.13647

Macedo, D. (2021). Introduction to the 50th Anniversary Edition. In P. Freire (Ed.), *Pedagogy of the Oppressed, 50th Anniversary Edition*. Bloomsbury Academic.

Macevicius, C., Gudiño Pérez, D., Norton, A., Kolla, G., Beck-McGreevy, P., Selfridge, M., Kalicum, J., Hutchison, A., Urbanoski, K., & Barker, B. (2024). Just have this come from their prescription pad: The medicalization of safer supply from the perspectives of health planners in BC, Canada. *Drugs: Education, Prevention and Policy*, *31*(6), 658-668.

Maracle, L. (2017). *My conversations with Canadians*. Book Hug Press.

Marker, M. (2009). Indigenous voice, community, and epistemic violence: The ethnographer's 'interests' and what 'interests' the ethnographer. In A. Y. Jackson & L. A. Mazzei (Eds.), *Voice in qualitative inquiry: Challenging conventional, interpretive, and critical conceptions in qualitative research*. Routledge. E-book edition.

Marsh, T. N., Coholic, D., Cote-Meek, S., & Najavits, L. M. (2015). Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance use disorder in Aboriginal peoples who live in northeastern Ontario, Canada. *Harm reduction journal*, *12*(1), 1-12.

Marshall, S. G. (2015). Canadian drug policy and the reproduction of Indigenous inequities. *International Indigenous Policy Journal*, *6*(1), 1-19.

Martens, K. (2024). Feds failing at health care reconciliation and nursing is at the heart of the issue: Union. *APTN News*. https://www.aptnnews.ca/national-news/feds-failing-at-health-care-reconciliation-and-nursing-is-at-the-heart-of-the-issue-union/

Martín-Moruno, D. (2020). A female genealogy of humanitarian action: Compassion as a practice in the work of Josephine Butler, Florence Nightingale and Sarah Monod. *Medicine, Conflict and Survival*, *36*(1), 19-40.

Mason, D. J., Nixon, L., Glickstein, B., Han, S., Westphaln, K., & Carter, L. (2018). The Woodhull study revisited: Nurses' representation in health news media 20 years later. *Journal of Nursing Scholarship*, *50*(6), 695-704.

Massoglia, M., & Remster, B. (2019). Linkages between incarceration and health. *Public Health Reports*, *134*(1_suppl), 8S-14S.

McCallum, K. (2013). Distant and intimate conversations: Media and Indigenous health policy in Australia. *Critical Arts*, *27*(3), 332-351.

McCallum, K., & Waller, L. (2017). The dimensions of mediatized policy-making in Australian Indigenous affairs. *Communications*, *42*(2), 173-193.

McCallum, M., Lavoie, J. G., Big Canoe, C., & Browne, A. (2021). Brian Sinclair, Joyce Echaquan died years apart in hospitals. Only one of their inquests points to change. *CBC News*. https://www.cbc.ca/news/opinion/opinion-sinclair-echaquan-inquest-contrast-1.6204930

McCallum, M., & Lux, M. K. (2022). Medicare versus medicine chest: Court challenges and treaty rights to health care. In E. Jones, J. Hanley, & D. Gavrus (Eds.), *Medicare's histories: Origins, omissions, andopportunities in Canada* (pp. 103-130). University of Manitoba Press.

McCallum, R., Medved, M. I., Hiebert-Murphy, D., Distasio, J., Sareen, J., & Chateau, D. (2020). Fixed nodes of transience: Narratives of homelessness and emergency department use. *Qualitative Health Research*, *30*(8), 1183-1195.

McCubbin, L. D., McCubbin, H. I., Zhang, W., Kehl, L., & Strom, I. (2013). Relational well-being: An Indigenous perspective and measure. *Family Relations*, *62*(2), 354-365.

McDonald, L. (2010). Florence Nightingale: Passionate statistician. *Journal of Holistic Nursing*, *28*(1), 92-98.

McDonald, L. (2011). *Florence Nightingale on wars and the war office: Collected works of Florence Nightingale* (Vol. 15). Wilfrid Laurier Univ. Press.

McGibbon, E., Mulaudzi, F. M., Didham, P., Barton, S., & Sochan, A. (2014). Toward decolonizing nursing: The colonization of nursing and strategies for increasing the counter-narrative. *Nursing Inquiry*, *21*(3), 179-191.

McKeown, I., Reid, S., & Orr, P. (2004). Experiences of sexual violence and relocation in the lives of HIV infected Canadian women. *International Journal of Circumpolar Health*, *63*(2), 399-404.

Mendes, M., Bordignon, J. S., Menegat, R. P., Schneider, D. G., Vargas, M. A. d. O., Atherina dos Santos, E., & Rodrigues da Cunha, P. (2021). Neither angels nor heroes: Nurse speeches during the COVID-19 pandemic from a Foucauldian perspective. *Revista Brasileira de Enfermagem*, *75*, e20201329.

Michaud, L., Kolla, G., Rudzinski, K., & Guta, A. (2024). Mapping a moral panic: News media narratives and medical expertise in public debates on safer supply, diversion, and youth drug use in Canada. *International Journal of Drug Policy*, *127*, 104423.

Miller, H. N., LaFave, S., Marineau, L., Stephens, J., & Thorpe Jr, R. J. (2021). The impact of discrimination on allostatic load in adults: An integrative review of literature. *Journal of Psychosomatic Research*, *146*, 110434.

Milliken, A. (2018). Nurse ethical sensitivity: An integrative review. *Nursing Ethics*, *25*(3), 278-303.

Minich, K., Saudny, H., Lennie, C., Wood, M., Williamson-Bathory, L., Cao, Z., & Egeland, G. M. (2011). Inuit housing and homelessness: Results from the international polar year Inuit health survey 2007-2008. *International Journal of Circumpolar Health*, *70*(5), 520-531.

Moeke-Pickering, T., Cote-Meek, S., & Pegoraro, A. (2018). Understanding the ways missing and murdered Indigenous women are framed and handled by social media users. *Media International Australia*, *169*(1), 54-64.

Moffatt, J., Mayan, M., & Long, R. (2013). Sanitoriums and the Canadian colonial legacy: The untold experiences of tuberculosis treatment. *Qualitative Health Research*, *23*(12), 1591-1599.

Moffitt, P. M., & Robinson Vollman, A. (2006). At what cost to health? Tlicho women's medical travel for childbirth. *Contemporary Nurse*, *22*(2), 228-239.

Monchalin, R., Smylie, J., & Bourgeois, C. (2020). "It's not like I'm more Indigenous there and I'm less Indigenous here.": Urban Métis women's identity and access to health and social services in Toronto, Canada. *AlterNative: An International Journal of Indigenous Peoples*, *16*(4), 323-331. https://doi.org/10.1177/1177180120967956

Monsour, M., Lee, J.-Y., & Borlongan, C. (2023). An understated comorbidity: The impact of homelessness on traumatic brain injury. *Neurotherapeutics*, *20*(6), 1446-1456.

Mulholland, J. (1995). Nursing, humanism and transcultural theory: The 'bracketing-out'of reality. *Journal of Advanced Nursing*, *22*(3), 442-449.

Mullaly, B. (2001). Confronting the politics of despair: Toward the reconstruction of progressive social work in a global economy and postmodern age. *Social Work Education*, *20*(3), 303-320.

Muñiz, R. (2024). Exploring litigation of anti-CRT state action: Considering the issues, challenges & risks in a time of White backlash. *Syracuse Law Review*, *74*, 1071.

Muschi, C. (2024, July 12, 2024). Pierre Poilievre calls supervised consumption sites 'drug dens'. *CBC News*. https://www.cbc.ca/news/canada/british-columbia/supervised-consumption-site-scale-back-poilievre-1.7262063

Myers, C. R. (2022). Racial reckoning: Can nursing organizations and nurses prompt necessary changes? *Journal of Psychosocial Nursing and Mental Health Services*, *60*(11), 3-5.

Nairn, R., Barnes, A. M., Rankine, J., Borell, B., Abel, S., & McCreanor, T. (2011). Mass media in Aotearoa: An obstacle to cultural competence. *New Zealand Journal of Psychology*, *40*(3).

Nairn, R., DeSouza, R., Barnes, A. M., Rankine, J., Borell, B., & McCreanor, T. (2014). Nursing in media-saturated societies: Implications for cultural safety in nursing practice in Aotearoa New Zealand. *Journal of Research in Nursing*, *19*(6), 477-487.

Naldemirci, Ö., Britten, N., Lloyd, H., & Wolf, A. (2021). Epistemic injustices in clinical communication: The example of narrative elicitation in person-centred care. *Sociology of Health & Illness*, *43*(1), 186-200.

Narang, S. K., Fingarson, A., Lukefahr, J., Abuse, C. O. C., Sirotnak, A. P., Flaherty, E. G., Gavril, C., Gilmartin, H., Bird, A., & Haney, S. B. (2020). Abusive head trauma in infants and children. *Pediatrics*, *145*(4).

Narvaez, J. C., Magalhães, P. V., Trindade, E. K., Vieira, D. C., Kauer-Sant'Anna, M., Gama, C. S., von Diemen, L., Kapczinski, N. S., & Kapczinski, F. (2012). Childhood trauma, impulsivity, and executive functioning in crack cocaine users. *Comprehensive Psychiatry*, *53*(3), 238-244.

Nath, N., & Allen, W. S. (2022). Settler colonial socialization in public sector work: Moving from privilege to complicity. *Studies in Social Justice*, *16*(1), 200-226.

National Inquiry Into Missing and Murdered Indigenous Women and Girls. (2019a). *A legal analysis of genocide: Supplementary report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Supplementary-Report_Genocide.pdf

National Inquiry Into Missing and Murdered Indigenous Women and Girls. (2019b). *Reclaiming power and place: The final report of the National Inquiry Into Missing and Murdered Indigenous Women and Girls*. https://www.mmiwg-ffada.ca/final-report/

Nelson, S. E., Browne, A. J., & Lavoie, J. G. (2016). Representations of Indigenous peoples and use of pain medication in Canadian news media. *International Indigenous Policy Journal*, *7*(1), 1-26.

Nestel, S. (1998). (Ad) ministering angels: Colonial nursing and the extension of empire in Africa. *Journal of Medical Humanities*, *19*(4), 257-277.

Neufeld, S. D. (2023). *Ending stigma for whom? A critical community-based participatory research project to examine Canadian substance use-focused anti-stigma campaigns* [Doctoral Dissertation, Simon Fraser University]. British Columbia.

Ng, S. L., Wright, S. R., & Kuper, A. (2019). The divergence and convergence of critical reflection and critical reflexivity: implications for health professions education. *Academic Medicine*, *94*(8), 1122-1128.

Nightingale, F. (1860). *Notes on nursing: What it is, and what it Is not*. D. Appleton and Company, New York. https://www.google.ca/books/edition/Notes_on_Nursing

Nightingale, F. (1863). *Sanitary statistics of native colonial schools and hospitals*. London: G. Eyre and W. Spottiswoode.

Norman, T., & Pauly, B. (2013). Including people who experience homelessness: A scoping review of the literature. *International journal of sociology and social policy*, *33*(3/4), 136-151.

Oelke, N. D., Thurston, W. E., & Turner, D. (2016). Aboriginal homelessness: A framework for best practice in the context of structural violence. *International Indigenous Policy Journal*, *7*(2).

Oliver, K. (2000). Beyond recognition: Witnessing ethics. *Philosophy Today*, *44*(1), 31-43.
Oliver, K. (2001). *Witnessing: Beyond recognition*. University of Minnesota Press.
Oliver, K. (2003). Subjectivity and subject position: The double meaning of witnessing. *Studies in Practical Philosophy*, *3*(2), 132-143.
Oliver, K. (2004). Witnessing and testimony. *parallax*, *10*(1), 78-87.
Oliver, K. (2015). Witnessing, recognition, and response ethics. *Philosophy & Rhetoric*, *48*(4), 473-493.
Olson, N., & Pauly, B. (2021). Homeless encampments: Connecting public health and human rights. *Canadian Journal of Public Health*, *112*(6), 988-991.
Orr, P. (2013). Tuberculosis in Nunavut: Looking back, moving forward. *CMAJ: Canadian Medical Association Journal*, *185*(4), 287-288. https://doi.org/10.1503/cmaj.121536
Osmancevic, S., Schoberer, D., Lohrmann, C., & Großschädl, F. (2021). Psychometric properties of instruments used to measure the cultural competence of nurses: A systematic review. *International Journal of Nursing Studies*, *113*, 103789.
Palma, C., Abdou, A. S., Danforth, S., & Griffiths, A. J. (2024). Are deficit perspectives thriving in trauma-informed schools? A historical and anti-racist reflection. *Equity & Excellence in Education*, *57*(1), 76-92.
Paradis-Gagné, E., Pariseau-Legault, P., Villemure, M., & Chauvette, S. (2020). A critical ethnography of outreach nursing for people experiencing homelessness. *Journal of Community Health Nursing*, *37*(4), 189-202.
Patel, S. A. (2022). Talking complicity, breathing coloniality: Interrogating settler-centric pedagogy of teaching about white settler colonialism. *Journal of Curriculum and Pedagogy*, *19*(3), 211-230.
Patrick, C. (2014). *Aboriginal homelessness in Canada: A literature review*. Canadian Homelessness Research Network Press. https://www.homelesshub.ca/sites/default/files/AboriginalLiteratureReview.pdf
Patton, K. R., & Kaliel, E. B. (2020). Building community and transforming knowledge: Histories of women's health practitioners and community-based health services in 20th-century Alberta, Canada. *Canadian Bulletin of Medical History*, *37*(2), 427-460.
Pauktuutit Inuit Women of Canada. (2017). *Understanding the needs of urban Inuit women: Final report*. www.pauktuutit.ca/project/understanding-the-needs-of-urban-inuit-women-final-report/
Pauly, B. (2005). *Close to the street: The ethics of access to health care* [Doctoral Dissertation, University of Victoria]. http://dspace.library.uvic.ca/bitstream/handle/1828/770/pauly_2005.pdf
Pauly, B. (2008). Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice. *International Journal of Drug Policy*, *19*(3), 195-204.
Pauly, B. (2014). Close to the street: Nursing practice with people marginalized by homelessness and substance use. In M. Guirguis-Younger, S. W. Hwang, & R. McNeil (Eds.), *Homelessness and health in Canada* (pp. 211). University of Ottawa Press.
Pauly, B., Gray, E., Perkin, K., Chow, C., Vallance, K., Krysowaty, B., & Stockwell, T. (2016). Finding safety: A pilot study of managed alcohol program participants' perceptions of housing and quality of life. *Harm reduction journal*, *13*(1), 15. https://doi.org/10.1186/s12954-016-0102-5

Pauly, B., Revai, T., Marcellus, L., Martin, W., Easton, K., & MacDonald, M. (2021). "The health equity curse": Ethical tensions in promoting health equity. *BMC Public Health*, *21*(1), 1-11.

Perres, J. (1859). *Legislative Council of Victoria 1858-1859 Report of the select commitee of the legislative council on the Aborigines; together with the proceedings of the comittee, minutes of evidence, and appendices*. https://aiatsis.gov.au/sites/default/files/catalogue_resources/92768.pdf

Pescosolido, B. A., Halpern-Manners, A., Luo, L., & Perry, B. (2021). Trends in public stigma of mental illness in the US, 1996-2018. *JAMA Network Open*, *4*(12), e2140202-e2140202.

Peters, E. (2005). Indigeneity and marginalisation: Planning for and with urban Aboriginal communities in Canada. *Progress in Planning*, *4*(63), 327-404.

Phillips-Beck, W., Eni, R., Lavoie, J. G., Avery Kinew, K., Kyoon Achan, G., & Katz, A. (2020). Confronting racism within the Canadian healthcare system: Systemic exclusion of First Nations from quality and consistent care. *International Journal of Environmental Research and Public Health*, *17*(22), 8343. https://doi.org/10.3390/ijerph17228343

Phyfer, J., Durrheim, K., & Murray, A. J. (2020). Buttressing whiteness by confessing guilt and rejecting racism: A study of white-talk about paid domestic labour. *South African Review of Sociology*, *51*(1), 3-16.

Piatkowski, T., Seear, K., Reeve, S., & Kill, E. (2024). How do relational practices co-constitute care for people who use drugs? The social and political dimensions of peer-led harm reduction. *International Journal of Drug Policy*, *133*, 104614.

Pilon, B. (2008). *The Necessities of Life* Association coopérative de productions audio-visuelles; Seville Pictures.

Poikkeus, T., Numminen, O., Suhonen, R., & Leino-Kilpi, H. (2014). A mixed-method systematic review: Support for ethical competence of nurses. *Journal of Advanced Nursing*, *70*(2), 256-271.

Poilievre, P. (2022). *Everything feels broken* Retrieved November 20, 2024 from https://www.youtube.com/watch?v=UvvMfwUkXrM

Pon, G. (2009). Cultural competency as new racism: An ontology of forgetting. *Journal of Progressive Human Services*, *20*(1), 59-71.

Porsanger, J. (2004). An essay about Indigenous methodology. *Nordlit*, *8*(1), 105-120. https://munin.uit.no/bitstream/handle/10037/906/article.pdf

Power, T., Wilson, D., Best, O., Brockie, T., Bearskin, L. B., Millender, E., & Lowe, J. (2020). COVID-19 and Indigenous Peoples: An imperative for action. *Journal of Clinical Nursing*, *29*(15-16), 2737.

Preston, T. (2014). *Inquest into the death of Brian Loyd Sinclair*. Retrieved from https://www.manitobacourts.mb.ca/site/assets/files/1051/brian_sinclair_inquest_-_dec_14.pdf

Public Health Agency of Canada. (2013). *The chief public health officer's report on the state of public health in Canada: Infectious disease—The never-ending threat: Tuberculosis—Past and present*. Retrieved from www.phac-aspc.gc.ca/cphorsphcrespcacsp/2013/tuber-eng.php

Rady, F., & Sotomayor, L. (2024). Barred and banished: Encampment evictions, public space, and permanent displaceability in Toronto. *Antipode*, *56*(5), 1830-1856.

Rafferty, A. M., & Solano, D. (2007). The rise and demise of the Colonial Nursing Service: British nurses in the colonies, 1896–1966. *Nursing History Review*, *15*(1), 147-154.

Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu* [Doctoral Dissertation, Victoria University of Wellington Wellington]. https://croakey.org/wp-content/uploads/2017/08/RAMSDEN-I-Cultural-Safety_Full.pdf

Rand, J. (2020). *Qun'ngiaqtiarlugu (taking a closer look) at Inuit Qaujimajatuqangit in community-based participatory research* [Doctoral Dissertation, Dalhousie University]. http://hdl.handle.net/10222/79478

Randall, W., Baldwin, C., McKenzie-Mohr, S., McKim, E., & Furlong, D. (2015). Narrative and resilience: A comparative analysis of how older adults story their lives. *Journal of Aging Studies*, *34*, 155-161.

Randall, W. L. (2016). Narrative environments for narrative care: The need to honor people's stories. *International Journal for Human Caring*, *20*(3), 142-145. https://doi.org/10.20467/1091-5710-20.3.142

Rasheed, S. P., Younas, A., & Mehdi, F. (2020). Challenges, extent of involvement, and the impact of nurses' involvement in politics and policy making in in last two decades: An integrative review. *Journal of Nursing Scholarship*, *52*(4), 446-455.

Registered Nurses' Association of Ontario. (2007). *Healthy work environments best practice guideline: Embracing cultural diversity in health care: Developing cultural competence*. https://rnao.ca/bpg/guidelines/embracing-cultural-diversity-health-care-developing-cultural-competence

Reo, N. J. (2019). Inawendiwin and relational accountability in Anishnaabeg studies: The crux of the biscuit. *Journal of Ethnobiology*, *39*(1), 65-75.

Ricciardelli, R., Whitten, C., & Johnston, M. (2024). "How are we gonna get them off the drugs if they're allowed to stay on it?" Correctional officer perspectives on overdose prevention sites in prisons. *Criminal Justice Studies*, *37*(1), 39-58.

Richardson, C., Carriere, J., & Boldo, V. (2017). Invitations to dignity and well-being: Cultural safety through Indigenous pedagogy, witnessing and giving back! *AlterNative*, *13*(3), 190-195. https://doi.org/10.1177/1177180117714413

Richardson, C., & Reynolds, V. (2014). Structuring safety in therapeutic work alongside indigenous survivors of residential schools. *Canadian Journal of Native Studies*, *34*(2), 147-164.

Richardson, L. (2020). Quebec rejects 'Joyce's Principle' because it calls for recognition of systemic racism. *APTN National News*. https://www.aptnnews.ca/featured/quebec-rejects-joyces-principle-because-it-calls-for-recognition-of-systemic-racism/

Rigney, L.-I. (1999). Internationalization of an Indigenous anticolonial cultural critique of research methodologies: A guide to Indigenist research methodology and its principles. *Wicazo sa review*, *14*(2), 109-121.

Ritland, L., Thomas, V., Jongbloed, K., Zamar, D. S., Teegee, M. P., Christian, W.-K., Richardson, C. G., Guhn, M., Schechter, M. T., & Spittal, P. M. (2021). The Cedar Project: Relationship between child apprehension and attempted suicide among young Indigenous mothers impacted by substance use in two Canadian cities. *PLoS ONE [Electronic Resource]*, *16*(6), e0252993.

Roberston, M. E. (2023). Bringing evidence back from the dead: A history of interference in science in Canada. *Dalhousie Journal of Interdisciplinary Management*, *17*.

Roe, G. (2005). Harm reduction as paradigm: Is better than bad good enough? The origins of harm reduction. *Critical Public Health*, *15*(3), 243-250.

Rogers, W., Mackenzie, C., & Dodds, S. (2012). Why bioethics needs a concept of vulnerability. *IJFAB: International Journal of Feminist Approaches to Bioethics*, *5*(2), 11-38.

Rogoff, I. (2003). From criticism to critique to criticality. *European Institute for Progressive Cultural Policies*. https://transversal.at/transversal/0806/rogoff1/en

Rogoff, I. (2006). Smuggling: An embodied criticality. *European Institute for Progressive Cultural Policies*, *2*, 1-7.

Rosales, R., Janssen, T., Yermash, J., Yap, K. R., Ball, E. L., Hartzler, B., Garner, B. R., & Becker, S. J. (2022). Persons from racial and ethnic minority groups receiving medication for opioid use disorder experienced increased difficulty accessing harm reduction services during COVID-19. *Journal of substance abuse treatment*, *132*, 108648.

Roseneil, S. (2012). *Doing feminist social research after the cultural turn: Research with practical intention*. Springer.

Rosino, M. L., & Hughey, M. W. (2018). The war on drugs, racial meanings, and structural racism: A holistic and reproductive approach. *American Journal of Economics and Sociology*, *77*(3-4), 849-892.

Rowe, R. K., Rowat, J., & Walker, J. D. (2020). First Nations' survivance and sovereignty in Canada during a time of COVID-19. *American Indian culture and research journal*, *44*(2), 89-100.

Roxburgh, S., & Sinclair, M. (2024). Colonial constructions: Systemic racism in child welfare practice. *Journal of Social Work*, *24*(1), 3-20.

Royal Commission on Aboriginal Peoples. (1996). *Report of the Royal Commission on Aboriginal Peoples: Volume 1 looking forward, looking back.* https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/final-report.aspx

Rumford-Rodgers, H., Giles, A. R., & Scobie, W. (2022). Christian summer camps for Indigenous youth in Canada: A settler colonial analysis. *Leisure/Loisir*, *47*(2), 159-179.

Russell, L. (2020). Settler colonial studies: Eliminating the native and creating the nation. *Postcolonial Studies*, *23*(1), 153-159.

Russell, N. C., & Flynt Wallington, S. (2022). Structural racism in America: A summative content analysis of national nursing organization statements. *Policy, Politics, & Nursing Practice*, *23*(2), 85-97.

Sakamoto, I. (2007). An anti-oppressive approach to cultural competence. *Canadian Social Work Review/Revue Canadienne de Service Social*, *24*(1), 105-114.

Salloum, A. (2024, January 25, 2024). Minister suggests old drug policy 'wasn't working' amid increase in HIV, overdoses. *Regina Leader Post*. https://leaderpost.com/news/politics/minister-suggests-old-drug-policy-wasnt-working-amid-increase-in-hiv-overdoses

Samuels-Wortley, K. (2021). To serve and protect whom? Using composite counter-storytelling to explore Black and Indigenous youth experiences and perceptions of the police in Canada. *Crime & delinquency*, *67*(8), 1137-1164.

Sanders, L. (2021). *"Knowledge of Every Home:" Health Sovereignty, Native Nurses' Labor, and the Field Nurse Program in the Early Twentieth Century*. The University of Iowa.

Sanders, L. (2024). Federal field nurses and Indigenous births. *Medical Humanities*, *50*(2), 235-245.

Sane, P. (2001). United Nations educational, scientific and cultural organization address by Mr. Pierre Sane head of the UNESCO delegation to WCAR and assistant director-general for

social and human sciences. World Conference Against Racism, Durban, South Africa, 31 August - 7 September 2001.

Sarkonak, J. (2024, Februrary 26, 2024). Jamie Sarkonak: Homeless camps deserve to be stigmatized. *National Post*. https://nationalpost.com/opinion/jamie-sarkonak-homeless-camps-deserve-to-be-stigmatized

Schmidt, R., Hrenchuk, C., Bopp, J., & Poole, N. (2015). Trajectories of women's homelessness in Canada's 3 northern territories. *International Journal of Circumpolar Health*, *74*, 29778. https://doi.org/10.3402/ijch.v74.29778

Schuelke, L. K. (2017). *Nursing reservations: White field nurses, scientific medicine, and settler colonialism, 1924-1955*. The University of Nebraska-Lincoln.

Schultheiss, K. (2010). Imperial nursing: Cross-cultural challenges for women in the health professions: A historical perspective. *Policy, Politics, & Nursing Practice*, *11*(2), 151-157.

Scott, S. M., & Scott, P. A. (2021). Nursing, advocacy and public policy. *Nursing Ethics*, *28*(5), 723-733.

Sellin, S. C. (1995). Out on a limb: A qualitative study of patient advocacy in institutional nursing. *Nursing Ethics*, *2*(1), 19-29.

Senese, L. C., & Wilson, K. (2013). Aboriginal urbanization and rights in Canada: Examining implications for health. *Social Science & Medicine*, *91*, 219-228.

Senger, D. (2025, Febuary 1, 2025). Trump Blames D.E.I. and Biden for Crash Under His Watch. *The New York Times*. https://www.nytimes.com/2025/01/30/us/politics/trump-plane-crash-dei-faa-diversity.html

Shah, S. (2021). *Twenty years later: Family's continued battle for media coverage of their missing and murdered Indigenous women and girls* [Masters Thesis, Brock University]. St. Catharines, Ontario.

Shahid, H., & Neufeld, S. (2024). Lay perspectives on drug (de)criminalization and the (de)stigmatization of people who use illicit drugs. *Contemporary Drug Problems*, 1-19. https://doi.org/10.1177/00914509241292479

Shahram, S., Bottorff, J., Kurtz, D., Oelke, N., Thomas, V., & Spittal, P. (2017). Understanding the life histories of pregnant-involved young Aboriginal women with substance use experiences in three Canadian cities. *Qualitative Health Research*, *27*(2), 249-259. https://doi.org/10.1177/1049732316657812

Sherwin, S., & Stockdale, K. (2017). Whither bioethics now? The promise of relational theory. *IJFAB: International Journal of Feminist Approaches to Bioethics*, *10*(1), 7-29.

Shuster, E. (1997). Fifty years later: The significance of the Nuremberg Code. *New England Journal of Medicine*, *337*(20), 1436-1440.

Silver, H., Sarmiento, I., Pimentel, J.-P., Budgell, R., Cockcroft, A., Vang, Z. M., & Andersson, N. (2022). Childbirth evacuation among rural and remote Indigenous communities in Canada: A scoping review. *Women and Birth*, *35*(1), 11-22.

Simons, E., Martindale, A., & Wylie, A. (2020). Bearing witness: What can archaeology contribute in an Indian Residential School context? In *Working with and for Ancestors* (pp. 21-31). Routledge.

Simpson, L. B., Walcott, R., & Coulthard, G. (2018). Idle no more and Black lives matter: An exchange (panel discussion). *Studies in Social Justice*, *12*(1), 75-89.

Singh, B. (2015). *More than just headlines: A critical examination of media response to missing and murdered Indigenous women in Canada* [Masters Thesis, University of Ottawa].

Sinha, V. (2017). Florence Nightingale (1820–1910). In *Sociological Theory Beyond the Canon* (pp. 269-301). Springer.

Skamski, S. [S. Skamski]. (2024, August 20, 2024). X (Formerly Twitter). Retrieved December 18, 2024 from https://x.com/Skamski/status/1826070881074032966

Smiles, C., O'Donnell, A., & Jackson, K. (2023). Needle exchange practitioners accounts of delivering harm reduction advice for chemsex: Implications for policy and practice. *Drugs: Education, Prevention and Policy*, *30*(3), 250-258.

Smith, L. T. (2021). *Decolonizing methodologies: Research and Indigenous Peoples, third edition*. Zed Books.

Smye, V., Browne, A. J., Josewski, V., Keith, B., & Mussell, W. (2023). Social suffering: Indigenous Peoples' experiences of accessing mental health and substance use services. *International Journal of Environmental Research and Public Health*, *20*(4), 3288.

Snelgrove, C., Dhamoon, R., & Corntassel, J. (2014). Unsettling settler colonialism: The discourse and politics of settlers, and solidarity with Indigenous nations. *Decolonization: Indigeneity, Education & Society*, *3*(2).

Spear Chief-Morris, J. (2020). *Indigenous land claims and reconciliation: The importance of land and relationship between Indigenous Nations and the Government of Canada* [Masters Thesis, The University of Western Ontario]. Ontario, Canada.

Spenceley, S. M., Reutter, L., & Allen, M. N. (2006). The road less traveled: Nursing advocacy at the policy level. *Policy, Politics, & Nursing Practice*, *7*(3), 180-194.

Spitzer, A. J. (2024). The settler-rights backlash: Understanding liberal challenges to Indigenous self-determination. *Territory, Politics, Governance*, *12*(5), 573-590.

Spivak, G. C. (1994). Can the Subaltern Speak? In P. C. Williams, Laura (Ed.), *Colonial Discourse and Postcolonial Theory: A Reader* (pp. 66-111). Columbia University Press.

St. Arnaud, K. O. (2023). Toward a positive psychology of psychoactive drug use. *Drugs: Education, Prevention and Policy*, *30*(1), 81-94.

Stake-Doucet, N. (2020). The racist lady with the lamp. *Nursing Clio*. https://nursingclio.org/2020/11/05/the-racist-lady-with-the-lamp/

Stake-Doucet, N. (2023). White privilege and professionalization: A decolonial and critical feminist perspective on professional nursing. *Witness: The Canadian Journal of Critical Nursing Discourse*, *5*(2), 26-38.

Starblanket, G., & Hunt, D. (2020). *Covid 19, the Numbered Treaties and the politics of life*. The Yellowknife Institute. https://yellowheadinstitute.org/covid-19-treaties/

Starrs, C. J., & Békés, V. (2024). Historical intergenerational trauma transmission model: A comprehensive framework of family and offspring processes of transgenerational trauma. *Traumatology*. https://doi.org/10.1037/trm0000505

Statistics Canada. (2016). *Aboriginal population profile, 2016 census Ottawa - Gatineau (Ontario part) [census metropolitan area], Ontario*. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd

Stefanick, L., & Tait, M. J. (2024). Crisis in care: Structural poverty, colonization and child apprehensions in Canada. *Canadian Journal of Political Science/Revue canadienne de science politique*, *57*(1), 174-194.

Stievano, A., & Tschudin, V. (2019). The ICN code of ethics for nurses: A time for revision. *International Nursing Review*, *66*(2), 154-156.

Stoffregen, T. A., Mantel, B., & Bardy, B. G. (2017). The senses considered as one perceptual system. *Ecological Psychology*, *29*(3), 165-197.

Stokes-Parish, J., Barrett, D., Elliott, R., Massey, D., Rolls, K., & Credland, N. (2023). Fallen angels and forgotten heroes: A descriptive qualitative study exploring the impact of the angel and hero narrative on critical care nurses. *Australian Critical Care*, *36*(1), 3-9.

Stroffolini, T., & Stroffolini, G. (2024). Prevalence and modes of transmission of hepatitis C virus infection: A historical worldwide review. *Viruses*, *16*(7), 1115.

Stubbs, J. L., Thornton, A. E., Sevick, J. M., Silverberg, N. D., Barr, A. M., Honer, W. G., & Panenka, W. J. (2020). Traumatic brain injury in homeless and marginally housed individuals: A systematic review and meta-analysis. *The Lancet Public Health*, *5*(1), e19-e32.

Sue, K. L. (2021). Supporting any positive change: Harm reduction as an integral pillar of opioid use disorder teatment. *Treating Opioid Use Disorder in General Medical Settings*, 143-159.

Swales, D. A., Davis, E. P., Mahrer, N. E., Guardino, C. M., Shalowitz, M. U., Ramey, S. L., & Schetter, C. D. (2023). Preconception maternal posttraumatic stress and child negative affectivity: Prospectively evaluating the intergenerational impact of trauma. *Development and psychopathology*, *35*(2), 619-629.

Symenuk, P. M., Tisdale, D., Bearskin, D. H. B., & Munro, T. (2020). In search of the truth: Uncovering nursing's involvement in colonial harms and assimilative policies five years post Truth and Reconciliation Commission. *Witness: The Canadian Journal of Critical Nursing Discourse*, *2*(1), 84-96.

Tasker, J. (2025). Trump complains about Canada — but new data shows spike in U.S. drugs and guns coming north. *CBC News*. https://www.cbc.ca/news/politics/trump-complaints-drugs-guns-border-1.7457605

Teillet, J. (2019). *The north-west is our mother*. HarperCollins Publishers Ltd.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117-125.

The Canadian Observatory on Homelessness. (n.d.). *Homeless Hub: Community Profiles*. Retrieved May 2, 2024 from https://www.homelesshub.ca/

Thistle, J., & Smylie, J. (2020). Pekiwewin (coming home): Advancing good relations with Indigenous people experiencing homelessness. *CMAJ*, *192*(10), E257-E259.

Thistle, J. A. (2017). *Indigenous definition of homelessness in Canada*. Canadian Observatory on Homelessness Press. https://homelesshub.ca/sites/default/files/COHIndigenousHomelessnessDefinition.pdf

Thurston, K. L., Zhang, S. J., Wilbanks, B. A., Billings, R., & Aroke, E. N. (2023). A systematic review of race, sex, and socioeconomic status differences in postoperative pain and pain management. *Journal of PeriAnesthesia Nursing*, *38*(3), 504-515.

Tisdale, D., & Symenuk, P. M. (2020). Human rights and nursing codes of ethics in Canada 1953–2017. *Nursing Ethics*, *27*(4), 1077-1088.

Troian, M. (2016). 20 years since Royal Commission on Aboriginal Peoples, still waiting for change. *CBC News*. https://www.cbc.ca/news/indigenous/20-year-anniversary-of-rcap-report-1.3469759

Truth and Reconciliation Commission. (2015). Honouring the Truth, Reconciling for the Future Summary of the Final Report of the Truth and Reconciliation Commission of Canada. http://www.trc.ca/websites/trcinstitution

Truth, S. (2020). *Ain't I a woman?* Penguin UK.

Tuck, E. (2009). Suspending damage: A letter to communities. *Harvard educational review*, *79*(3), 409-428.

Tuck, E., & Yang, K. (2012). Decolonization is not a metaphor. *Decolonization: Indigeneity, Education & Society*, *1*(1), 1-40.

Tuck, E., & Yang, K. W. (2014). Unbecoming claims: Pedagogies of refusal in qualitative research. *Qualitative Inquiry*, *20*(6), 811-818.

Tung, M., Jackson, J., Ferreira, C., Hayden, K. A., & Ens, T. (2023). Strategies for addressing needle debris: A scoping review of needle debris and discarded drug paraphernalia associated with substance use. *International Journal of Drug Policy*, *120*, 104183.

Ungpakorn, R., & Rae, B. (2020). Health-related street outreach: Exploring the perceptions of homeless people with experience of sleeping rough. *Journal of Advanced Nursing*, *76*(1), 253-263.

United Nations. (1948). *United Nations Universal Declaration of Human Rights*. https://www.un.org/en/about-us/universal-declaration-of-human-rights

United Nations. (2007). *United Nations Declaration on the Rights of Indigenous Peoples*. https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html

United Nations. (2015). *Study on the impact of the world drug problem on the enjoyment of human rights: Report of the United Nations High Commissioner for Human Rights* (A/HRC/30/65, Issue. United Nations General Assembly Human Rights Council. https://digitallibrary.un.org/record/804342?ln=en&v=pdf

Valderama-Wallace, C. P., & Apesoa-Varano, E. C. (2020). 'The problem of the color line': Faculty approaches to teaching social justice in baccalaureate nursing programs. *Nursing Inquiry*, *27*(3), e12349.

Valverde, M. (2004). A postcolonial women's law? Domestic violence and the Ontario liquor board's" Indian list," 1950-1990. *Feminist Studies*, *30*(3), 566-588.

Van Boekel, L. C., Brouwers, E. P., Van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and alcohol dependence*, *131*(1-2), 23-35.

Van Herk, K. A., Smith, D., & Andrew, C. (2011). Examining our privileges and oppressions: Incorporating an intersectionality paradigm into nursing. *Nursing Inquiry*, *18*(1), 29-39.

van Santen, D. K., Lodi, S., Dietze, P., Van Den Boom, W., Hayashi, K., Dong, H., Cui, Z., Maher, L., Hickman, M., & Boyd, A. (2023). Comprehensive needle and syringe program and opioid agonist therapy reduce HIV and hepatitis c virus acquisition among people who inject drugs in different settings: A pooled analysis of emulated trials. *Addiction*, *118*(6), 1116-1126.

Varcoe, C., Browne, A., & Cender, L. (2014). Promoting social justice and equity by practicing nursing to address structural inequities and structural violence. In P. N. Kagan, M. C. Smith, & P. L. Chinn (Eds.), *Philosophies and practices of emancipatory nursing: Social justice as praxis* (pp. 266-284). Routledge.

Varcoe, C., Wathen, N., Ford-Gilboe, M., Smye, V., & Browne, A. (2016). VEGA briefing note on trauma-and violence-informed care. *VEGA Project and PreVAiL Research Network*.

Viens, J. (2019). *Public inquiry commission on relations between Indigenous Peoples and certain public services in Québec: Listening, reconciliation and progress.* https://www.cerp.gouv.qc.ca/fileadmin/Fichiers_clients/Rapport/Final_report.pdf

Villar, F., & Serrat, R. (2017). Changing the culture of long-term care through narrative care: Individual, interpersonal, and institutional dimensions. *Journal of Aging Studies*, *40*, 44-48.

Villar, F., Serrat, R., & Bravo-Segal, S. (2019). Giving them a voice: Challenges to narrative agency in people with dementia. *Geriatrics*, *4*(1), 12.

Virani, H. N., & Haines-Saah, R. J. (2020). Drug decriminalization: A matter of justice and equity, not just health. *American journal of preventive medicine*, *58*(1), 161-164.

Waite, R., & Nardi, D. (2019). Nursing colonialism in America: Implications for nursing leadership. *Journal of Professional Nursing*, *35*(1), 18-25.

Walker, D., & Myrick, F. (2006). Grounded theory: An exploration of process and procedure. *Qualitative Health Research*, *16*(4), 547-559.

Wardman, D., & Quantz, D. (2006). Harm reduction services for British Columbia's First Nation population: A qualitative inquiry into opportunities and barriers for injection drug users. *Harm reduction journal*, *3*(30). https://doi.org/10.1186/1477-7517-3-30

Ware, V. (1992). *Beyond the pale: White women, racism, and history*. Verso Books.

Weber, J. J. (2019). A systematic review of nurse-led interventions with populations experiencing homelessness. *Public Health Nursing*, *36*(1), 96-106.

Wesp, L. M., Scheer, V., Ruiz, A., Walker, K., Weitzel, J., Shaw, L., Kako, P. M., & Mkandawire-Valhmu, L. (2018). An emancipatory approach to cultural competency: The application of critical race, postcolonial, and intersectionality theories. *Advances in Nursing Science*, *41*(4), 316-326.

Whitten, C., Turner, A., Howell, B., Sparkes, B., Ricciardelli, R., & Daley, P. (2023). Retrospective review of rates of sexually transmitted and blood-borne infection (STBBI) testing in provincial corrections facilities in Newfoundland and Labrador. *Journal of the Association of Medical Microbiology and Infectious Disease Canada*, *8*(2), 141-149.

Wiese, J. L., Watson, T. M., Owusu-Bempah, A., Hyshka, E., Wells, S., Robinson, M., Elton-Marshall, T., & Rueda, S. (2023). Overpoliced and underrepresented: Perspectives on cannabis legalization from members of racialized communities in Canada. *Contemporary Drug Problems*, *50*(1), 25-45.

Williamson, M., & Harrison, L. (2010). Providing culturally appropriate care: A literature review. *International Journal of Nursing Studies*, *47*(6), 761-769.

Wilson, K., Bell, T., Arreak, A., Koonoo, B., Angnatsiak, D., & Ljubicic, G. (2020). Changing the role of non-Indigenous research partners in practice to support Inuit self-determination in research. *Arctic Science*, *6*(3), 127-153.

Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Fernwood.

Wilson, S., & Wilson, P. (1998). Relational accountability to all our relations. *Canadian Journal of Native Education*, *22*(2), 155.

Wiseman, T. (1996). A concept analysis of empathy. *Journal of Advanced Nursing*, *23*(6), 1162.

Witham, G., & Haigh, C. (2018). Narrative intelligence in nursing: Storying patient lives in dementia care. *Nursing Inquiry*, *25*(3), e12244.

Wolfe, P. (2006). Settler colonialism and the elimination of the native. *Journal of genocide research*, *8*(4), 387-409.

Wood, P., & Schwass, M. (1993). Cultural safety: A framework for changing attitudes. *Nursing Praxis in New Zealand*, *8*(1), 4-15.

Woods, M. (2010). Cultural safety and the socioethical nurse. *Nursing Ethics*, *17*(6), 715-725.

Woods, M. (2012). Exploring the relevance of social justice within a relational nursing ethic. *Nursing Philosophy*, *13*(1), 56-65.

World Health Organization. (2010). *A conceptual framework for action on the social determinants of health*. https://www.who.int/publications/i/item/9789241500852

Yadollahi, S., Ebadi, A., & Asadizaker, M. (2020). Measuring cultural competence in nursing: A review study. *Journal of Client-Centered Nursing Care*, *6*(3), 203-212.

Zapata, F., Pastor-Ruiz, V., Ortega-Ojeda, F., Montalvo, G., Ruiz-Zolle, A. V., & García-Ruiz, C. (2021). Human ultra-weak photon emission as non-invasive spectroscopic tool for diagnosis of internal states–A review. *Journal of Photochemistry and Photobiology B: Biology*, *216*, 112141.

Žižek, S. (2021). *Pandemic! 2: Chronicles of a time lost*. Polity Press.