Chapter 4
Digital Compassion, Health Equity, and Cultural Safety: From the Therapeutic Relationship to the Organization of Virtual Care

Allison Crawford, Lisa Richardson, Emily Simmonds, David Wiljer, and Gillian Strudwick

Objectives

Through case-based and critical reflexive practice, the reader will be able to:

1. Define digital compassion and consider its manifestations at individual and organizational levels
2. Define digital health equity and reflect upon how this applies to the delivery of virtual care in rural and underserved communities
3. Define cultural safety and cultural humility and reflect upon the social positioning of the virtual provider
4. Consider the complex interplay of compassion, equity, and cultural safety as they apply to virtual care

A. Crawford (✉)
Virtual Mental Health, Centre for Addiction and Mental Health, Department of Psychiatry, University of Toronto, Toronto, ON, Canada
e-mail: Allison.crawford@utoronto.ca

L. Richardson
Temerty Faculty of Medicine, University of Toronto, Toronto, ON, Canada

E. Simmonds
Science and Technology Studies, York University, Centre for Wise Practices in Indigenous Health, Women's College Hospital, Toronto, ON, Canada

D. Wiljer
University Health Network, Institute of Health Policy, Management, and Evaluation, University of Toronto, Toronto, ON, Canada

G. Strudwick
Centre for Addiction and Mental Health, Institute of Health Policy, Management, and Evaluation, University of Toronto, Toronto, ON, Canada

© The Author(s), under exclusive license to Springer Nature Switzerland AG 2022
D. M. Hilty et al. (eds.), *Virtual Mental Health Care for Rural and Underserved Settings*, https://doi.org/10.1007/978-3-031-11984-2_4

Due to limited access to mental healthcare, and to often well-intentioned attempts to redistribute health human resources from over- to under-resourced areas, an increasing proportion of mental healthcare to rural and underserved areas is delivered virtually. At no time has the shift to virtual care been more marked than during the COVID-19 pandemic.

Compassion is our active attempt to be with people when they are suffering or in need, and virtual care and other forms of digital health technologies can extend our ability to "be there" even at a distance. There is also evidence that this virtual mode of "being with" can create therapeutic relationships that are as robust as in-person care (Simpson & Reid, 2014; Simpson et al., 2021), even in those experiencing severe mental illness (Tremain et al., 2020), a factor that is central to healing and recovery in mental health (Norcross & Lambert, 2018). We also simultaneously recognize that the idea of compassion emerges from a particular sociocultural context and how this choice situates our work in a Western academic frame rather than other axiological orientations, including Indigenous ones.

Even if we can provide compassionate care virtually, we must acknowledge that not all have access to this care (Crawford & Serhal, 2020). Equity barriers such as poverty and lack of access to digital technologies, or literacy with technology, can limit access to care and challenge the very notions of compassion. Similarly, if we use top-down approaches to being with people, without consideration of local context, community autonomy, and without awareness of power, then our attempts at compassionate access to care can create and perpetuate paternalism and strip people and communities of their autonomy to receive care in ways that are meaningful and relevant to them.

As systems of virtual care attempt to meet urgent and emergent needs, we need to shift our thinking from absolute access as a measure of success and critically consider the ways in which virtual care supports the mental well-being of people, organizations, and health systems and the ways in which it may disrupt local systems of care at all levels. In this chapter, we focus upon digital compassion and the ways that this intersects with digital health equity, with specific considerations for rural and underserved contexts. We also highlight the importance of ensuring cultural safety for individuals and communities that receive and participate in virtual care delivery and the cultural humility required of providers.

A core dimension of cultural humility is acknowledging our own social location. The authors of this chapter are of different ancestries, with A. Crawford, G. Strudwick, and D. Wiljer identified as Canadian and of European ancestry, L. Richardson as of mixed European and Anishinaabe ancestry, and E. Simmonds as mixed European and Métis (Red River) ancestry. We have also highlighted a case vignette of an Anishinaabe woman and her infant, adapted from a clinical scenario. We feel this case respectfully highlights important considerations in balancing compassion, equity, and cultural safety in virtual care. However, it is written from a general perspective rather than from an Indigenous worldview. It is also not intended to apply to all Indigenous Peoples, but rather highlight key considerations. Finally, although we highlight key considerations including cultural safety and cultural humility, we also acknowledge that this chapter does not fully explore the breadth

of Indigenous knowledges that should inform virtual care, the ongoing colonization of virtual "space," and the right to self-determination of Indigenous peoples.

Case Study

Mary is an Anishinaabe woman with an 18-month-old infant, living in a rural community in Northern Ontario, Canada. She attends a first virtual appointment from her apartment. You observe her looking withdrawn and sad, and she confirms multiple symptoms of depression beginning in the last trimester of her pregnancy. She is attentive to her daughter during the assessment, but does not smile upon interacting with her, and although it is difficult to ascertain this through televideo, she does not appear to be making eye contact with you as you complete the assessment. You feel somewhat uncomfortable as you are new to virtual care.

What can you do to establish a connection and relationship with this client?

The Therapeutic Relationship

Chapter 2 in this text focuses on how virtual care is transformed by taking a person-centered approach. A person-centered approach to virtual care requires centering patient choice, preferences, and values. The goal in taking a person-centered approach is ultimately to enhance patient health outcomes and to reduce unintended harms. The therapeutic alliance, sometimes termed the therapeutic relationship, describes the working relationship between provider and patient and includes shared goals for treatment and the presence of the provider's genuine concern, warmth, authenticity, and a collaborative bond. Indeed, in mental healthcare, it has long been established that the relationship between provider and patient is foundational to patient outcomes, as if not more important than the specific interventions used (Flückiger et al., 2018; O'Brien, 2001).

Relationship factors that create this alliance include the ability to foster mutuality and collaboration between provider and patient, working together to attain the patient's treatment goals. Important provider factors are the provider's ability to be flexible and responsive to the patient's needs, including gathering and incorporating patient feedback (Norcross & Lambert, 2018). Considerable evidence now demonstrates that it is possible to establish a therapeutic relationship in virtual care that patients rate as effective as in-person care (Simpson & Reid, 2014; Simpson et al., 2021; Tremain et al., 2020). Therapeutic viability is the specific term for the degree to which virtual care or televideo communication creates the potential for this relationship; in other words, which technologies are sufficient to establish that sense of connection. We consider this relationship as foundational for health providers to convey digital compassion.

Digital Compassion

If compassion is the ability to be with a person who is suffering, then digital compassion is the ability to convey that sense of being there and of responsiveness via technology. Digital compassion must achieve all of the dimensions of compassion, from registering awareness of another's need or suffering to the affective quality of compassion – "being moved" by another's suffering and then being driven to help (Wiljer et al., 2019). Compassion, thus, moves from the more passive domain of empathy to a more active stance in relation to patients (Wiljer et al., 2020). Because developing a therapeutic relationship requires an active stance on the part of the health provider, it is closely linked to compassionate action.

Digital compassion considers how the incorporation of digital tools into healthcare shapes the means and ability to deliver compassionate care. Digital devices and environments can either facilitate or pose barriers to compassionate care, including creating the conditions for developing a strong therapeutic relationship. These facilitators and barriers include the technology itself, but also the abilities of both provider and patient to engage with the technologies. Further, as our healthcare ecosystems continue to expand to include digital environments, we need to also consider contextual factors in digital compassion. Table 4.1 summarizes key facilitators of digital compassion, including those important to the therapeutic relationship, with concrete examples that apply to the case discussion.

1. *Technology factors*: Just as technologies like televideo conferencing can allow us to be with patients and increase access to healthcare, they can also get between providers and patients, sometimes literally such as a distracted provider attending to their electronic health record instead of interacting with a patient. In the provision of virtual care, aspects of the technology that facilitate access, provide a secure and reliable connection, and enable communication can also support the delivery of compassionate care and promote the development of a strong therapeutic relationship. Conversely impedances created by technology can be barriers to compassionate care.
2. *Provider factors*: Comfort with and the ability to use technology as a vehicle for compassion and the platform for forming the therapeutic relationship necessitate that providers have proficiency in the use of technologies and have developed competencies in the provision of virtual care. These include provider professionalism and self-care. Chapter 11 in this text explores provider well-being and its impacts on virtual care, including the ability to deliver compassionate care.
3. *Patient factors*: Patients with high digital literacy and comfort are more likely to derive the most benefit from virtual care and to experience it as compassionate. Patients bring many abilities and strengths to virtual care that should be acknowledged and leveraged, including the ability to perceive opportunities for virtual care, to reach and seek virtual care, ability to afford it, and to engage with it, all necessary to key implementation outcomes of virtual care, including approachability, acceptability, availability, affordability, and appropriateness, respectively (Levesque et al., 2013).

Table 4.1 Practical strategies for enhancing digital compassion

	Example: Mary
Technology Well-functioning, up-to-date technology and software Synchronous technology > asynchronous for therapeutic relationship Better connectivity allows for access and enhanced quality of connection Secure technology enables privacy and trust Higher-quality cameras placed at correct angles can approximate eye contact Better integration of different health technologies allows for more seamless care Availability of in-home technology to decrease need to travel	*Ensure Mary has appropriate technology and connectivity to participate in virtual care. Coaching around placement of cameras may enhance ability to make eye contact*
Patient level Offer choice, respect preferences and values Amplify digital literacy Seek feedback through evaluation Involve patients in co-design of service and technology	*Are there options for in person and virtual? Has Mary been able to exercise choice? Is she comfortable with technology? Ask her if she is in a private space – headphones can improve privacy* *You note the lack of eye contact – also explore whether there is patient and/or cultural preference involved* *Does your organization have opportunities for patient feedback, such as questionnaires?*
Provider level Ensure adequate training in virtual care Measure provider satisfaction Attend to self-care and well-being in virtual environments Appropriate supervision, performance assessments, and opportunities for formative feedback	*The case mentions that the provider is uncomfortable. Have there been opportunities for training? Have work schedules and protocols been adjusted to account for virtual care?*
Organizational level Have policies that support the delivery of compassionate digital care Sponsor training initiatives for providers, patients, families Provide resources for IT support and administration	*Does the provider's workplace offer policies and procedures that guide virtual care? Is there administration to support the booking and setup of this session? Is IT available for tech support?* *Does the referring organization have policies? What are the safety parameters for allowing patients to access care from home?*

4. *Organizational factors*: Although in the individual health encounter, the focus is on the provider-client interaction mediated by technology, many organizational factors shape the context for and the likelihood of digital compassionate care. The shifting of digital ecosystems of care requires health organizations to develop policies that support virtual care, and they have adequate technology and administration to facilitate care. Leadership, including champions in digital care, can ensure that digital compassionate care is a priority. Organizations can support training and promote programs that enhance the digital literacy of providers, patients, and families. Organizations and larger health systems must also recognize the important foundation of cybersecurity and privacy as important for trust at the patient level (see, e.g., Sequeira et al., 2022).

Case Study Continued

In a follow-up visit, Mary connects to the virtual visit from a parking lot. She is parked next to a library to take advantage of the wireless since she recently ran out of data. You discuss postpartum depression with Mary and review treatment options. You would like to find a parenting group for Mary, but there are none available in her area; you let her know you will explore virtual groups, but are unsure of the evidence for the use of virtual parenting groups. At the end of the appointment, Mary informs you that she will be moving back with her baby to her home reserve to be with her family. She would like to follow up with you, but thinks it may have to be by telephone instead of video.

What additional factors that you need to consider in order to provide compassionate care?

Digital Health Equity

This case highlights that even the most compassionate provider, with a strongly established therapeutic relationship with a client, can face additional barriers to providing compassionate care. Digital health equity refers to the ability of all to have equal digital healthcare access; equal access to interventions; equal choice between in-person, virtual, and blended models of care; and equal health outcomes. Digital health equity requires that virtual care and other health technologies be developed and adapted to meet the needs of diverse groups of people and be used to address health disparities rather than perpetuate or widen them (Strudwick et al., 2021).

Digital health equity necessitates understanding the delivery of care through a framework that guides consideration of social determinants of health and health

equity factors alongside digital determinants of health. The Digital Health Equity Framework (DHEA; Crawford & Serhal, 2020) takes an ecological approach to considering the cultural and economic forces that create social stratification whereby some individuals and communities differ in their access to prestige and resources. A person's social location is defined by intersectional factors such as race, age, income, geography, rurality, gender, ability, and occupation as well as other social factors. In turn, this social location governs exposure to health-related risks and vulnerabilities, including discrimination. A person's social location and material circumstances intersect with intermediate factors that shape health and health behaviors, including psychosocial stressors; styles of appraisal and coping; biology, including current health status and preexisting conditions; health-related beliefs and behaviors; current health needs; and their environment.

Digital determinants of health interact with these intermediate health factors. For example, access to digital health resources and digital health literacy interact with the degree and kind of psychosocial stress a person is currently experiencing; job loss or poverty, level of education, and previous exposure to digital media can all impact access to digital health. Styles of coping and appraisal of risk, along with health-related beliefs, can shape beliefs and behaviors regarding digital health; for example, some patients may have a tendency to avoid healthcare or to minimize risk, leading to issues such as corollary avoidance of digital healthcare, privacy-related concerns, or failure to appraise the quality of digital health information. Just as a person's environment shapes their healthcare access and quality, it also shapes their digital health access and quality. Figure 4.1 presents a simplified version of the DHEF.

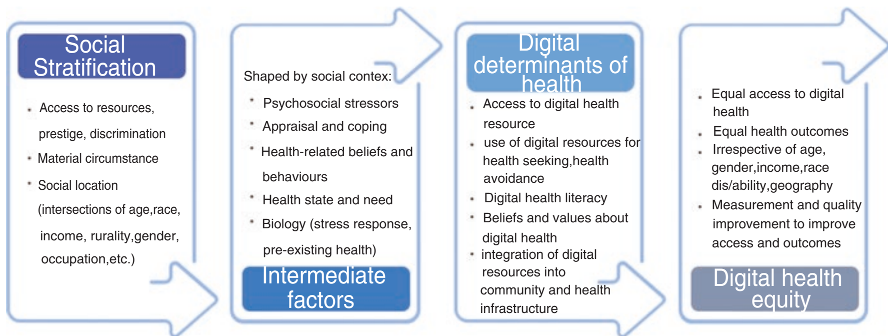

Fig. 4.1 Digital health equity factors. (Adapted from the Digital Health Equity Framework (Crawford & Serhal 2020))

Case Study Continued

Although you recognize the equity barriers that Mary's case highlights in your organization's ability to provide equitable access to care, you agree to continue to provide care via *telephone. At the same time, you use your role as a health advocate to call for better distribution of digital health resources, including technology and necessary resources such as internet connectivity. While you continue to recommend a parenting group, Mary becomes increasingly quiet during your phone appointments and then stops attending. She later sends you an email saying that she has opted to receive care from a local Elder and that her mother worries you will involve child protection services.*

What have you failed to account for in your care? What social, historical, and cultural factors should be considered in developing virtual care services?

Cultural Safety and Cultural Humility

The concept of cultural safety has its origins with the Māori of Aotearoa (New Zealand) (Wepa, 2015), arising in response to "the ongoing and long-term impact of the colonization process on Māori health outcomes" (ibid, p. 6). The core principles of cultural safety focus on health gains and positive outcomes, apply to all relationships within healthcare, identify the power relations between those who provide and those who deliver care and empower service users, and address the relationship of history, political, social, and employment status, housing, education, gender, and personal experience to current healthcare interactions (Nursing Council of New Zealand, 2011).

Providing care that patients and clients experience as cultural safety has proven useful in geographic areas beyond New Zealand, particularly given that racism within medicine continues to be a structural issue (Allan & Smylie, 2015). Brascoupé and Waters (2009) explore the relevance of cultural safety for Indigenous peoples in Canada (Crawford et al., 2021). Cultural safety "is used to express an approach to health care that recognizes the contemporary conditions of Aboriginal people which result from their post-contact history" (ibid, p. 5). Central to taking a culturally safe approach is recognizing that communities are heterogenous; First Nations, Inuit, and Métis may have different perspectives about what culturally safe care is. This emphasizes the importance of seeking guidance on community-specific values (Wilson et al., 2013).

There is limited literature available to date about what cultural safety in virtual care would look like (Ruiz-Cosignani et al., 2022; Hilty et al., 2020, 2021), but some common principles to ensure cultural safety include:

(i) Recognizing the importance of community involvement in identifying need and co-developing models of virtual care
(ii) Enhancing engagement with all rights holders
(iii) Working in partnership, with knowledge and power sharing
(iv) Understanding from individuals and communities what aspects of care can meaningfully be delivered virtually – consider language, the space(s) of care, the meaning of providing care disconnected to the land, culturally based interventions, etc.

(v) Looking for opportunities to promote community leadership and involving health leaders from the community
(vi) Recognizing that health equity is not equivalent with nor does it detract from the right to self-determination
(vii) Seeking to understand historical and current sources of stigma and racism within healthcare that may continue to undermine trust in health delivery, including the use of technologies in healthcare
(viii) Exploring collaborative models of care, such as including Elders and local care providers
(ix) Ensuring that providing virtual care does not bypass local health resources – establish multiorganization and system partnerships
(x) Measure cultural safety – ensure that the process of measurement is also culturally safe! and co-developed with the community/context

Many current efforts are being made to operationalize these concepts within the delivery of healthcare in Canada (Fung et al., 2012). The Indigenous Physicians Association of Canada (IPAC) and the Association of Faculties of Medicine of Canada, for example, have identified core competencies for practitioners working in the area of First Nations, Inuit, and Métis health (IPAC, 2010). They provide the following definition of cultural safety:

> Cultural safety refers to a state whereby a provider embraces the skill of self-reflection as a means to advancing a therapeutic encounter with First Nations, Inuit, Métis peoples and other communities including but not limited to visible minorities, gay, lesbian, transgendered communities, and people living with challenges. Self-reflection in this case is underpinned by an understanding of power differentials. (ibid, p. 9)

The Royal College of Physicians and Surgeons in Canada has sponsored an Indigenous Health Committee that has also created an Indigenous Health Primer (2019). Cultural safety principles challenge health providers to examine their own practices to recognize power relations and to understand their impact as a bearer of their own culture, history, attitudes, and life experiences.

Cultural humility is a more recent concept related to cultural safety. While cultural safety can only be determined by the healthcare recipient, cultural humility denotes the stance of the health provider. Cultural humility is "a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience" (First Nations Health Authority, 2019).

Best Practices and Lessons Learned: Practices That Support Building Accurate Compassion Through Equity and Cultural Safety

If we return to the case, we see that providing quality care to Mary involved creating not only access to care but also understanding how to deliver that care compassionately. Cultural humility returns us to reconsidering what digital compassion means

and to challenging and extending the definition of digital compassion. In many communities, what counts as "compassion" is freighted with a long history of the paternalism that has accompanied colonization. Without this critical perspective, digital compassion can be left within the purview of the health provider, bestowed based upon their feelings of being moved to action, and can threaten to disempower the recipient(s) of care. This also applies to the organizational level. Organizations that value and prioritize cultural safety will ensure adequate training in staff and will form necessary partnerships, in which power is shared, with stakeholders and communities.

In delivering virtual care in rural contexts, all of these perspectives are critical. Rural and underserved areas have many similarities, and development of virtual care can address many needs, particularly increasing access to mental healthcare. However, facilitating these opportunities requires consideration from the perspectives of the technology and infrastructure, patients and communities, and providers and organizations. Likewise, we need to remember that there is considerable heterogeneity within and between rural communities.

Figure 4.2 summarizes the interplay of perspectives and practices that move toward balancing digital compassion, digital health equity, and cultural safety within virtual care. Achieving this balance requires an ongoing and sustained stance of cultural humility on the part of providers and organizations. Beyond reflexive practice in the provision of healthcare, which centers the provider's experiences, knowledge, and feelings, critically reflection prompts us to focus "less on self and instead turns [our] gaze to personal and societal assumptions and unhelpful power relations, with the goal of improving how one practices one's chosen profession" (Ng et al., 2022). These considerations orient us to develop systems of virtual care with a commitment to ethics and justice.

CE/CME Questions

1. The therapeutic relationship or alliance differs in virtual care, compared to in-person care in the following ways:
   (a) There is less trust on the part of patients
   (b) Is rated lower in virtual settings by providers
   (c) It is not possible to establish virtually when the patient has severe mental illness
   (d) It is more challenging to do collaborative goal setting virtually

2. What qualities are *not* part of a compassionate response?
   (a) Acknowledging the suffering of others
   (b) Being moved to act to address another's suffering
   (c) Feelings of pity or sorrow
   (d) Being with another in their suffering

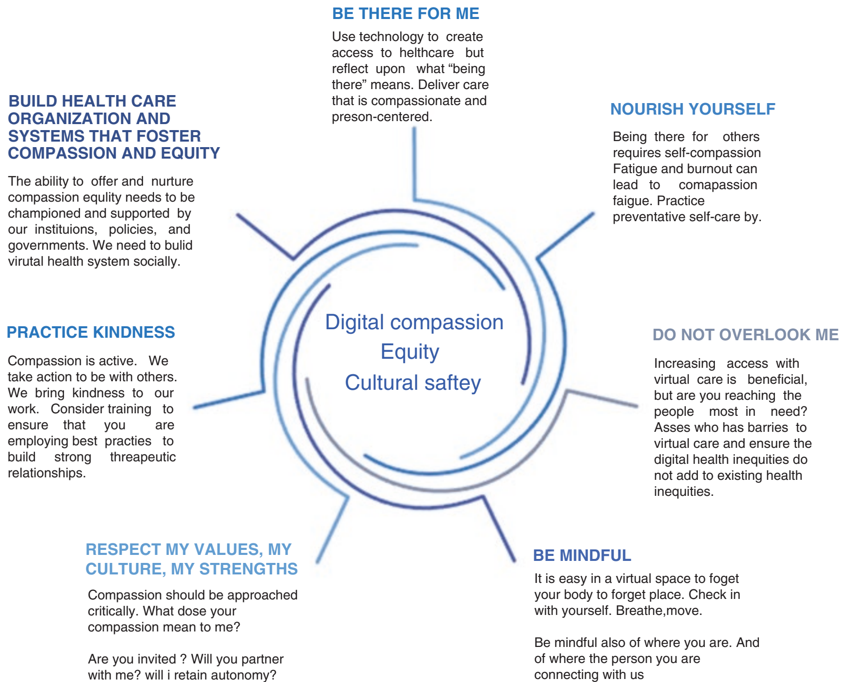

Fig. 4.2 Digital compassion, equity, and cultural safety within virtual care. (Adapted from Crawford, 2020)

3. Digital health equity relates most to:
   (a) Equal access to and equal health outcomes from digital health resources
   (b) A balance between accessing virtual and in-person care
   (c) Places that need virtual care more have greater access
   (d) Everyone has access to necessary digital devices
4. All of the following are digital determinants of health *except*:
   (a) Digital health literacy
   (b) Access to digital health resources
   (c) Use of digital health resources to seek healthcare
   (d) Choosing digital health over in-person options
5. Cultural safety is best determined by:
   (a) The provider of healthcare
   (b) The patient or recipient of health services
   (c) An Elder in the community
   (d) The health organization providing services

Answers

1. (b)
2. (c)
3. (a)
4. (d)
5. (b)

References

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*. Toronto (ON), The Wellesley Institute.

Brascoupé, S., & Waters, C. (2009). Cultural safety: Exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *Journal de la santé autochtone, 5*(2), 6–41.

Crawford, A. (2020, June 20). Compassionate care in a virtual world. *Healthy Debate*. https://healthydebate.ca/2020/06/topic/compassionate-care-virtual-world/

Crawford, A., & Serhal, E. (2020). Digital health equity and COVID-19: The innovation curve cannot reinforce the social gradient of health. *Journal of Medical Internet Research, 22*(6), e19361.

Crawford, A., Waddell, C., & Lund, C. (2021). Healing healthcare: Introducing a cultural safety curriculum for healthcare providers in Nunavut., Canada. In R. Schiff & H. Møller (Eds.), *Health and healthcare in the Canadian North*. University of Toronto Press.

First Nations Health Authority (BC). (2019). Cultural safety & humility. Available from http://www.fnha.ca/wellness/cultural-humility#learn

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316–340. https://doi.org/10.1037/pst0000172

Fung, K., Lo, H. T., Srivastava, R., & Andermann, L. (2012). Organizational cultural competence consultation to a mental health institution. *Transcultural Psychiatry, 49*(2), 165–184. https://doi.org/10.1177/1363461512439740

Hilty, D. M., Gentry, M. T., McKean, A. J., Cowan, K. E., Lim, R. F., & Lu, F. G. (2020). Telehealth for rural diverse populations: Telebehavioral and cultural competencies, clinical outcomes and administrative approaches. *Mhealth, 6*, 20. https://doi.org/10.21037/mhealth.2019.10.04

Hilty, D. M., Crawford, A., Teshima, J., et al. (2021). Mobile health and cultural competencies as a foundation for telehealth care: Scoping review. *Journal of Technology in Behavioral Science, 6*(2), 197–230. https://doi.org/10.1007/s41347-020-00180-5

Indigenous Physicians Association of Canada; The Association of Faculties of Medicine Canada. (2010). *First Nations, Inuit, Métis health core competencies: curriculum implementation toolkit for undergraduate education*. Indigenous Physicians Association of Canada; The Association of Faculties of Medicine Canada. Available from https://afmc.ca/sites/default/files/pdf/IPAC-AFM_FN_I_M_Health_Curriculum_Implementation_Toolkit_EN.pdf

Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health, 12*, 18. https://doi.org/10.1186/1475-9276-12-18

Ng, S. L., Crukley, J., Brydges, R., Boyd, V., Gavarkovs, A., Kangasjarvi, E., Wright, S., Kulasegaram, K., Friesen, F., & Woods, N. N. (2022). Toward 'seeing' critically: A Bayesian analysis of the impacts of a critical pedagogy. *Advances in Health Sciences Education: Theory and Practice, 27*(2), 323–354.

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy, 55*(4), 303–315. https://doi.org/10.1037/pst0000193

Nursing Council of New Zealand. (2011). *Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice*. Nursing Council of New Zealand.

O'Brien, A. J. (2001). The therapeutic relationship: Historical development and contemporary significance. *Journal of Psychiatric and Mental Health Nursing, 8*(2), 129–137. https://doi.org/10.1046/j.1365-2850.2001.00367.x

Royal College of Physicians and Surgeons of Canada. (2019). Indigenous Health Primer. https://www.royalcollege.ca/rcsite/health-policy/indigenous-health-e

Ruiz-Cosignani, D., Chen, Y., Cheung, G., Lawrence, M., Lyndon, M.P., Ma'u, E., & Ramalho, R. (2022). Adaptation models, barriers, and facilitators for cultural safety in telepsychiatry: A systematic scoping review. *Journal of Telemedicine and Telecare*, 1357633X211069664. https://doi.org/10.1177/1357633X211069664

Sequeira, L., Strudwick, G., De Luca, V., Strauss, J., & Wiljer, D. (2022). Exploring uniformity of clinical judgment: A vignette approach to understanding healthcare professionals' suicide risk assessment practices. *Journal of Patient Safety*. https://doi.org/10.1097/PTS.0000000000000973

Simpson, S., & Reid, C. (2014). Therapeutic alliance in videoconferencing psychotherapy: A review. *Australian Journal of Rural Health, 22*(6), 280–299. https://doi.org/10.1111/ajr.12149

Simpson, S., Richardson, L., Pietrabissa, G., Castelnuovo, G., & Reid, C. (2021). Videotherapy and therapeutic alliance in the age of COVID-19. *Clinical Psychology & Psychotherapy, 28*(2), 409–421. https://doi.org/10.1002/cpp.2521

Strudwick, G., Sockalingam, S., Kassam, I., Sequeira, L., Bonato, S., Youssef, A., Mehta, R., Green, N., Agic, B., Soklaridis, S., Impey, D., Wiljer, D., & Crawford, A. (2021). Digital interventions to support population mental health in Canada during the COVID-19 pandemic: rapid review. *JMIR Mental Health, 8*(3), e26550. https://doi.org/10.2196/26550

Tremain, H., McEnery, C., Fletcher, K., & Murray, G. (2020). The therapeutic alliance in digital mental health interventions for serious mental illnesses: Narrative review. *JMIR Mental Health, 7*(8), e17204. https://doi.org/10.2196/17204

Wepa, D. (Ed.). (2015). *Cultural safety in Aotearoa New Zealand* (2nd ed.). Cambridge University Press.

Wiljer, D., Charow, R., Costin, H., Sequeira, L., Anderson, M., Strudwick, G., Tripp, T., & Crawford, A. (2019). Defining compassion in the digital health age: Protocol for a scoping review. *BMJ Open, 9*(2), e026338. https://doi.org/10.1136/bmjopen-2018-026338

Wiljer, D., Strudwick, G., & Crawford, A. (2020). Caring in a digital age: Exploring the interface of humans and machines in the provision of compassionate healthcare. In B. Hodges, G. Paeche, & J. Bennet (Eds.), *Without compassion there is no healthcare: Leading with care in a technological age*. McGill University Press.

Wilson, D., de la Ronde, S., Brascoupé, S., Apale, A. N., Barney, L., Guthrie, B., Harrold, E., Horn, O., Johnson, R., Rattray, D., Robinson, N., & Aboriginal Health Initiative Committee. (2013). Health professionals working with First Nations, Inuit, and Métis consensus guideline. *Journal of Obstetrics and Gynaecology Canada, 35*(6), 550–558.