BUILDING EQUITABLE, CULTURALLY SAFE & TRAUMA-INFORMED HEALTH CARE: MENDING A BROKEN SYSTEM

A Field Practicum Report

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Abstract

This practicum report provides a description and critical analysis of my experience as a Master of Social Work (MSW) student during my field practicum placement with the Public Health Observatory (PHO), with the Saskatchewan Health Authority (SHA). The purpose of this practicum was to gain graduate-level experience and knowledge about the integration of knowledge and skills relevant to macro social work practice in areas focused on health equity, cultural safety, and the promotion of trauma-informed principles in a healthcare setting. This report will explore the literature on macro social work practice, health equity, cultural safety, narrative (storytelling) approaches, and trauma-informed care. The literature review also examines what is required to move from reflection to reflexivity. Finally, this field practicum report describes my experience engaging with these overarching themes in an effort to understand how healthcare systems can be transformed — a transformation that must include a critical, self-reflexive, and revolutionary dialogue about the direction we envision for health care in Saskatchewan.

*Keywords: health equity, cultural safety, trauma-informed healthcare*
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Introduction

The unequal and unfair representation of Indigenous peoples within societal structures and institutions such as health care, child welfare and the criminal justice system has been largely reported (Allen & Smylie, 2015; Baba, 2013; Boutilier & Mason, 2017; Government of Manitoba, 2014; McCallum & Perry, 2018; NAHO, 2008; Raphael, 2017; TRC, 2015a, TRC, 2015b; Wyatt, Laderman, Botwinick, Mate & Whittington, 2016).

The social, political and cultural influence of all of our human service organizations can be used for positive or negative purposes. The negative experiences of many people accessing healthcare services must be viewed not as an individual problem, but as a symptom of the breakdown of the social order and therefore something that concerns the entire community (Bloom, 1999; Bloom & Farragher, 2013; Burke-Harris, 2018).

The process of colonization, along with ongoing and entrenched racism against Indigenous peoples in particular, continues to significantly impact the health and well-being of Indigenous peoples in Canada and will be the primary focus of this document. Allen and Smylie (2015) argue that the reach of this impact spreads widely through each of the social determinants of health such as access to education, housing, food security and employment.

Opportunities for the profession of social work to engage with the prevention, reduction, and elimination of inequities in health care at a structural level, often referred to as macro practice (Kirst-Ashman & Hull, 2012), will be discussed in this final report. Understanding and navigating equity and cultural safety, and exploring how they are implemented (or fail to be) in health care systems and settings, largely guided the interactions and learning experience throughout this field practicum. This document will identify the
key learning experience of this practicum, which was focused on learning how an intentional, self-reflexive process was necessary to provide a better understanding of the trio of concepts guiding my practicum — cultural safety, health equity, and the adaptation of trauma-informed care.

Locating Self

My self-reflexive journey has made me look at many of my personal and educational experiences and has challenged me to consider and reconsider what it means to be a non-Indigenous ally to Indigenous peoples. Navigating when to use my voice versus when to stand beside, support, and learn from Indigenous peoples is an ongoing process. When I engage in “allyship”, I acknowledge my settler privilege, and am frequently looking to converse with others about theirs.

I identify as a cisgender, Caucasian woman of Scottish and English descent. Like many other non-Indigenous social workers, my family immigrated to Canada within the past century. I am able-bodied with no physical or mental disability, heterosexual, married, and have an extensive post-secondary education with permanent, unionized employment. Having identified these labels; most of which I recognize as social privilege and membership in a dominant group, given my Caucasian, European settler heritage; I am careful not to attach too much meaning to them. They are what I am but not who I am and will not define the type of social worker and ally I intend to become.

I come from a life of privilege; it’s simply what I was born into. I believe I have a responsibility to use that privilege to benefit others - whether on a small personal scale or on a larger population scale. Designing the project I am about to describe was important to me, both personally and professionally, having been employed as a social worker in
the healthcare system for nearly a decade. Although I was not practicing social work in a clinical capacity during this practicum, my experience as a clinician aided me throughout the project as I was cognizant of particular approaches (e.g. narrative therapy, strengths-based focus, or client-centred strategies) when eliciting stories about lived experience from clients or patients. I have witnessed and heard stories from patients describing racist encounters with healthcare professionals. Contrastingly, I have been a patient who has had positive experiences with hospital and community healthcare professionals. As an able-bodied, Caucasian woman, I have never once expected to be treated unfairly when accessing health care – or other services – because of how I identify or am perceived by others.

It was important to me to tell these stories in hopes that they might be used for education or awareness purposes. When reflecting on personal reasons for entering the MSW program, my intentions were to obtain the skills and experience to, at some point in my career, consider myself a qualitative researcher. It was not until I enrolled in an Indigenous social work course that I began to reflect on how it was the narrative, or storytelling framework, of qualitative research that I was drawn to.

As the owner of a photography/videography company, I have always sought to capture the candid, emotive moments during a family photo-shoot or wedding film. What may appear to be bloopers to clients is very much part of their story (e.g. toddlers’ unwillingness to look at the camera, unscripted laughter, tears, or embarrassing moments). It is the smallest of details that help tell someone’s story and will always be included in the final, artistic product. Yet, even though I value the power of the media and art in storytelling, I have come to realize that we often do not take time to listen to people’s stories
in an intentional way. Stories are built into the fabric of our culture, ideologies, beliefs, and values. And yet, the stories of Indigenous health in Canada told in mainstream society are generally not authored by Indigenous peoples themselves (Allen & Smylie, 2015).

What is needed in health care are opportunities that center Indigenous voices and perspectives on the experiences and impacts of racism on Indigenous health and well-being; in other words, a decolonizing approach (Baskin, 2016). Their voices and stories will only aid in promoting the political will necessary to foster the widespread acknowledgment that health inequities are faced by Indigenous peoples in Canada because of historical and ongoing trauma and colonization of Indigenous peoples.

Agency Description

The colonization of Indigenous peoples has created a society where receiving biased health care is often the standard for Indigenous peoples. However, there are agencies that are involved in addressing this issue in order to create better experiences of care and health outcomes. The Public Health Observatory (PHO), a department within Population and Public Health Services at the Saskatchewan Health Authority (SHA), serves as a champion of health equity and cultural safety. When it comes to this imbalance of treatment regarding healthcare experiences and Indigenous peoples, the PHO ensures these principles are included at both the frontline and policy discussion levels in health care. Therefore, this department was identified as appropriate in meeting my learning objectives of exploring and applying leading practices in promoting and supporting reconciliation, decolonization, and trauma-informed principles in healthcare settings.

Having been employed in health care for over a decade prior to commencing my field practicum, I was aware that the amalgamation of the province’s 12 individual health
regions into a single health authority was taking place on December 4, 2017, just prior to the completion of this field practicum. When selecting this placement, I intentionally looked for an environment that would play a role in this health system transition and would allow for a greater understanding of the ensuing changes, improvements, and/or problems in healthcare delivery. The PHO, within the SHA, is a multidisciplinary environment and provided a unique opportunity to explore and develop macro practice philosophies and skills within a healthcare setting.

The timing of this field practicum was unique because it occurred at a time when there was collaborative and revolutionary dialogue going on about the direction for healthcare in Saskatchewan. There was energy and enthusiasm among healthcare professionals in anticipating these changes, and this included those in leadership positions, as well as frontline practitioners. There was also resistance, apathy, skepticism, and fear because the role that the Public Health Observatory would play in the development of the SHA’s new provincial healthcare structure was unclear during my time in the practicum placement. However, there was a sense communicated among the team that the services and expertise of the PHO was valued by senior leaders and that they would likely be part of different phases of the design of the new system.

The team at the Public Health Observatory includes several epidemiologists, two information technology analysts, a health information practitioner, a researcher/evaluation consultant, a geographic information system (GIS) analyst, and one knowledge translation specialist (my field practicum supervisor). It is not a typical environment for a social worker to be employed in, and yet, for someone interested in macro practice and larger system change, it was well positioned to host a graduate-level social work student
in an advanced experiential practicum placement given its multidisciplinary team and strategic priorities of health equity and cultural safety, which this paper will soon describe in greater detail.

As someone whose professional experience has been limited to the areas of acute mental health and addictions, I suspected there would be a learning curve to engaging in and initiating learning opportunities in this placement. Despite initial reservations, I decided to trust the process and slowly began to lean into the messiness of a macro-practice environment and look for ways in which I could bring my skills and experiences to the work while also meeting my learning goals and objectives.

**Practicum Goals and Objectives**

The overarching goal of this practicum placement was to advance my knowledge and skills relevant to macro social work practice. My practicum supervisor at the PHO, a knowledge translator with a social work background, provided the support for this unique learning opportunity. More specifically, during the placement, I sought to 1) review and critically analyze SHA policy relating to patient engagement and health equity; and 2) explore and apply leading practices in promoting and supporting allyship, reconciliation, decolonization, and trauma-informed principles in healthcare settings.

I would like to draw the reader’s attention to the fact that a conscious decision has been made to write a significant portion of this paper using a first-person narrative. The intent behind this was to demonstrate how I have internalized the theme that threads throughout each of the frameworks within this practicum - the importance of maintaining a critically self-reflexive stance when engaging in allyship and culturally humble prac-
tice. According to the literature, one solution to the problem of inequities and of decolonizing our practice and the system(s) we work in as social workers is maintaining conscious awareness and a critically reflexive stance (Banaji & Greenwald, 2013; Baskin, 2016). To do this, there are elements of storytelling and a level of vulnerability that is required (Brown, 2010), which is why I made the decision to interject my voice and my critical interpretations throughout this report.

**Practicum Report Overview**

The planning of this practicum placement involved exploring the overall healthcare system and efforts underway, or necessary, to improve health for populations that are most negatively impacted by inequities. In particular, I was interested in dialogue and engagement as it relates to reconciling the relationship with Indigenous peoples. I looked into the literature to see what researchers were saying about three specific terms: health equity, culturally safe health care, and trauma-informed care. During the months of September to December 2017, I sought to understand the concepts of health equity and cultural safety by putting healthcare policy into practice or, at the very least, witnessing healthcare workers as they attempted to integrate the concepts of health equity and cultural safety in their work.

By the end of the semester, my experience in this practicum helped me achieve a deeper understanding of how the healthcare system is actively engaging in, and working to address, the social determinants of health. In particular, I learned more about how these determinants are impacting Canadians, including Indigenous peoples. I was given the opportunity to serve on various committees and subcommittees and participate in a variety of conference calls and multi-day conferences. More specifically, I reached this
deeper understanding largely because of two overarching projects I had the opportunity to be a part of: the design and implementation of a small qualitative research project titled *Indigenous Experiences of Cultural Safety in the Saskatoon Health Region*; and the second opportunity focused on the delivery of a presentation for the managers and senior staff in the Population and Public Health Department titled *Building Trauma-Informed Teams*.

Given the fact that this unique practicum focused on identifying macro practice opportunities to learn and critically reflect on the work being done (or not done) in health care, I was also encouraged to become familiar with the two concepts integral to the Public Health Observatory: health equity and cultural safety. The next section offers a summary of academic research in these two areas, beginning with an overview of how these concepts intersect with the healthcare system from a macro perspective.

**Literature Review**

When fairness and health intersect, health equity can be achieved (Braveman, 2014). Health equity takes many social factors into account when trying to accomplish this idea of *fairness*. Whitehead and Dahlgren (2006) argue that no one should be at a disadvantage due to these social factors. Cultural safety in health care deals with the connection between respecting patients’ cultures while simultaneously providing quality health care (Baba, 2013; NAHO, 2008). Unfortunately, Indigenous peoples can experience obstacles when it comes to experiencing both cultural safety and health equity, and that’s where reflecting on oneself as a healthcare provider - looking at how one’s culture may be oppressing people - becomes critical and necessary.
Health Equity

Health equity refers to “the principle of, and commitment to, incorporating fairness into health by reducing health inequalities” (SHR, 2016a, p. 1). The term implies that all people can reach their full health potential and “should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, sexual orientation, age, disability, social class, geographical location, socioeconomic status, or other socially determined circumstances” (SHR, 2016a, p. 1).

Health inequity occurs in the absence of health equity. According to Braveman (2014), health inequities are defined as

… systematic, potentially avoidable differences in health—or in the major socially determined influences on health—between groups of people who have different relative positions in social hierarchies according to wealth, power or prestige. [T]hese differences adversely affect the health…of groups already at a disadvantage by virtue of their underlying social positions. (p. 181)

Health inequities in Canada are widespread and manifest in “… numerous indicators of health outcomes across the life-course” (Raphael, 2017, p. 147). For example, the average life expectancy of residents living in the least advantaged neighbourhoods in Saskatoon is eight years lower than residents in the most advantaged neighbourhoods (SHR, 2017). These gaps that exist between residents in more advantaged neighbourhoods and residents in less advantaged neighbourhoods in Saskatchewan are deplorable. And yet, the span of differences between the two groups exist through many health conditions over the last 15 years, including in reference to injuries, intentional self-harm, diabetes, heart disease, and mental health disorders (SHR, 2017).
In 2016, the Saskatoon Health Region (currently the SHA) released their Health Equity Position Statement (HEPS) that formally declared its commitment to improving health outcomes for all people within the region. The HEPS reflects a commitment to working to eliminate health inequities, providing equitable health services, and ensuring that patients, clients, residents, families, staff, and communities experience culturally safe care (SHR, 2016a). Similar to the principle of, and commitment to, cultural safety, the HEPS intends to ensure that quality care is available to everyone and that the quality of care provided does not differ because of race, ethnicity, or other personal characteristics unrelated to a patient’s reason for seeking care (Braveman, 2014; SHR, 2016a).

The Saskatchewan Health Authority (SHA) has spent a great deal of time and resources to define their vision, mission, and values as they relate to health equity (Neudorf et al., 2014). It remains to be seen if, in the years following the amalgamation to one province-wide health authority, the commitment to equitable healthcare standards and reconciliation will continue to remain a priority. Ideally, a similar commitment will be developed for, and endorsed by, SHA. Reports detailing the extent to which health inequities present themselves within Saskatchewan are often informed by the work and research of the PHO, where this field practicum took place.

Historically, the reports issued by the Public Health Observatory have demonstrated how certain segments of the population, mainly racialized minorities, often encounter obstacles when seeking appropriate, equitable, or culturally safe health care in our communities. For example, a report on the rates of HIV in Saskatchewan sheds light on the overrepresentation of Indigenous peoples living with the virus (SHR, 2014). Furthermore, almost seven in every ten newly reported HIV and AIDS cases since 2009 were
within the Indigenous population. From this data, the reader is able to surmise that a health disparity, or inequity, potentially exists for Indigenous peoples as they may be unfairly or unjustly exposed to HIV and AIDS due to a host of structural, social, and economic factors as described in the report by the Saskatoon Health Region (2014).

The next section will discuss how I have come to understand cultural safety and its intrinsic value to reconciliation. The term cultural safety refers to more than just guidelines for the healthcare system to follow on a quest for decolonized, equitable care. Cultural safety is an outcome that is difficult to achieve because it not only refers to a psychological feeling of safety on the part of the patient or client, but also to a process that requires simultaneous and critical self-reflection on the part of the healthcare provider.

**Cultural Safety, Competency, and Humility**

There is a significant difference among the three terms that define this section. A brief description of each and discussion how each complement one another in a healthcare professional’s journey to providing culturally safe care is necessary.

**Cultural Safety**

Cultural safety guidelines were first approved for nurses practicing in New Zealand in 1992 by the Nursing Council of New Zealand (NCNZ) as a response to the poor health status of the Māori, the Indigenous peoples of New Zealand (NCNZ, 2011). Prompted by Māori nurses, the *Treaty of Waitangi* was signed by the British Crown and the Māori chiefs. This document recognizes two distinct cultures, that of Māori, the Indigenous or original peoples of New Zealand; and that of Pakeha/European New Zealanders, the colonizers. Following the signing of this treaty, a process of self-examination
and change in nursing education and service delivery began (NCNZ, 2011; Ramsden, 1996).

The original definition of cultural safety was related to determining the effectiveness of nursing practice on a person/family from another culture by nurses who had undertaken a process of reflection on their own cultural identity. This original definition recognizes the impact of the nurses’ culture on their own nursing practices (NCNZ, 2011; Ramsden, 1996). Since its introduction in 1992, the concept of cultural safety has continued to be refined. While its original focus was on improving the health status of New Zealanders, it has been further developed to include a critical self-awareness of power relationships between healthcare providers and patients worldwide (Baskin, 2016; Richardson, Yarwood & Richardson, 2017). Arguably, what is most valuable about the concept of cultural safety is that it encourages, within the healthcare system, reflection on racism, power relations, one’s own privilege and status, as well as the oppression/marginalization and status of those we serve.

Today, the definition of cultural safety emphasizes that the experience of cultural safety can only be defined and assessed by those who receive health care; it is considered culturally safe if the patients’ cultural identities and meanings are respected and they do not encounter discrimination (NCNZ, 2011). Nursing Council New Zealand (2011) also provides a broader definition of the concept that goes beyond ethnic groups:

…cultural safety education is delivered according to the Council’s definition, which is broad in its application and extends beyond ethnic groups to include age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and
disability. (p. 5)

Ultimately, regardless of how culturally sensitive, attuned, or informed we think we have been as healthcare providers, the concept of cultural safety is concerned with how safe the patient or client believes their healthcare experience was in terms of being respected and assisted in having their cultural location, values, and preferences taken into account (Ball, 2008; NCNZ, 2011). For example, when Indigenous peoples access healthcare services, they might feel culturally safe if they receive responsive, respectful, and quality care.

Today’s definition of cultural safety also involves clear indicators of when cultural unsafety has occurred. According to Ball (2008), these indicators include:

…low utilization of available services, ‘denial’ of suggestions that there is a problem, ‘non-compliance’ with referrals or prescribed interventions, reticence in interactions with practitioners, anger, low self-worth, complaints about lack of ‘cultural appropriateness’ of tools and interventions transported from dominant culture to minority culture. (pp. 1-2)

Unfortunately, many people who identify as part of a non-dominant group (e.g. Indigenous people, non-English speakers, LGBTQ people, and non-dominant religious groups) cannot be confident that they will experience culturally safe care due to frequent previous experiences of racism and discrimination in the health system. Instead, they may experience their cultural identity, beliefs, and world view being dismissed, misunderstood, or criticized by healthcare professionals (e.g. doctor, nurses, social workers, etc.) who are part of dominant cultural, linguistic, or religious groups. The negative, often racist, experiences that Indigenous peoples face when accessing healthcare services often
result in elevated levels of stress and trauma, and reduced likelihood of accessing needed health care and health conditions becoming worse (Allan & Smylie, 2015).

The prevalence of negative experiences of non-dominant groups accessing healthcare services is likely why cultural safety is often understood as it is related to practices that might be viewed *culturally unsafe* such as “any actions which diminish, demean, or disempower the cultural identity and wellbeing of an individual” (Baskin, 2016, p. 88). Experiences of cultural unsafety can occur during the most subtle experiences, such as participating in a program of care (e.g. inpatient, or residential treatment) or service (e.g. prenatal care or blood transfusions). It could also occur during something as critical as going to the emergency department only to be misdiagnosed, or, as the next story will describe, to not be given any care presumably due to ingrained prejudices regarding Indigenous peoples.

Ball (2008), in a poster presented at The Early Years Interprofessional Research and Practice Conference in Vancouver, February 1, 2008, describes five principles that can increase the likelihood that a person seeking help will feel respected, included, and protected in terms of their cultural identity, cherished values and goals. These five principles include “protocols, personal knowledge, partnerships, process, and positive purpose” (see Appendix C) (Ball, 2008).

**Indigeneity & Cultural Safety**

A tragic example of how Indigenous peoples have been treated in the Canadian healthcare system is evident in a story arising out of a Winnipeg hospital. In this story, spanning only a thirty-four hour period in September 2008, a middle-aged, double ampu-
A non-Status Anishinaabeg resident named Brian Sinclair arrived at the emergency department. Because health care staff believed him to be intoxicated, escaping the cold, or already discharged, he was not attended to, assessed, nor treated, and ultimately died from an easily treatable infection. It was a story, a preventable negative outcome that sparked a national response and dialogue. An official inquest was ordered to determine the factors that led to his death. The lawyer for Sinclair’s family argued for an investigation into the health system issues as it was “impossible to separate the systemic issues - whether his race, his disability, his socio-economic status affected the treatment he received, or the indifference he received” (Government of Manitoba, 2017).

The provincial inquiry into the death of Brian Sinclair, released December 12th, 2014 (Government of Manitoba, 2014) included 63 recommendations for changes within the healthcare system; many of which included cultural safety training for staff. However, the report has been criticized for omitting any consideration of underlying factors, including racism and systemic discrimination (McCallum & Perry, 2018). Due to a lack of action from the province and hospital, a group of concerned Canadian experts formed The Brian Sinclair Working Group to further examine the role of racism in the death of Brian Sinclair and in the inquest that followed in order to highlight ongoing structural and systemic anti-Indigenous racism in the health and legal systems in Manitoba. The Working Group, following careful research and contemplation, released its interim report *Out of Sight* in 2017 (Government of Manitoba, 2017). The report features several recommendations aimed at addressing the negative bias that exists towards Indigenous peoples in health care systems and settings.
Now, ten years after this tragic outcome, Mr. Sinclair’s story serves as a reminder about the importance of a commitment to equitable and culturally safe health care. It also urges us to understand that the perceptions we have and (often unconscious) assumptions we make about people impact how we deliver care; assumptions that this practicum report will discuss later in greater detail. Stories like this one reveal the ongoing history of colonialism and should inspire us to action because Brian Sinclair could have lived if he had been provided with the appropriate emergency care and the necessities of life such as food and water, instead of being left unattended in an emergency department (Government of Manitoba, 2017; McCallum & Perry, 2018).

The principles and practices which contribute to culturally safe care have been adopted into fields of health care and social services in the United States, the United Kingdom and Australia, and in Canada have been embraced by the Assembly of First Nations and the National Aboriginal Health Organization (NAHO) as being an ideal approach to working with Indigenous communities (Baskin, 2016). Creating greater health equity and experiences of cultural safety have been identified as priorities of the Saskatoon Health Region, which issued a public declaration of its Commitment to Reconciliation on Friday, October 14, 2016 (SHR, 2016b). Recently, the Saskatchewan Health Authority reaffirmed their commitment to reconciliation and signed a similar public commitment on March 4th, 2019 (SHA, 2019).

At present, one of the ways that the healthcare system demonstrates its commitment to truth and reconciliation is by regularly offering cultural responsiveness and cultural safety training for its staff. It is important to remember these terms are not synonymous with cultural sensitivity, awareness, or competency. Comparing cultural safety to
cultural competency is the most significant misinterpretation of cultural safety (Nursing Council New Zealand, 2011; Ramsden, 1996).

**Cultural Competency**

The term *cultural competency* implies that an organization has the capacity to function effectively within the context of cultural beliefs, behaviours, values, social norms, and needs of the patients and their communities of origin, or residence (Baskin, 2016). Similarly, there is a belief that a culturally unsafe experience can be mitigated with the recognition and incorporation of a culturally-competent workforce.

Cultural competency training has been argued to not go far enough in keeping workers accountable for the privileged and powerful position their role innately holds (Baskin, 2016). It also fails to acknowledge all people as bearers of culture (some of those cultures are dominant, some are not – and it’s important to acknowledge that health care providers and system staff can experience cultural (un)safety and variations in power/privilege due to ethnocultural and other identities in the workplace) – it is an inherently *othering* paradigm. According to Brascoupe and Waters (2009), the reason cultural competence falls far short is because it “leaves the power of the interaction in the hands of the professional... Knowledge of Aboriginal cultures may be helpful, but it is not necessary for a culturally safe interaction to take place (p. 29).

One of the reasons the healthcare system moved away from a cultural competency-based model is that this model has not resulted in an increase in culturally safe care, primarily because it doesn’t consider reflection on the service provider’s own culture, power, trauma, safety, and the voices/perspectives/assessments of people who access services. A culturally competent workforce might believe they know and understand
the culture of others, but there is typically failure to know and understand the nuanced individual expressions and experiences of culture, not to mention one’s own cultural experiences and perspectives and how these relate to the provision of care (Brascoupe & Waters, 2009).

The perspective of a privileged person typically fails to acknowledge the socio-structural mechanisms and institutional processes that prescribe and proscribe social injustices as a consequence of cultural differences when compared to the mainstream, dominant society. For example, when practitioners come to believe they have a certain degree of cultural literacy when it comes to ethnic or linguistic minorities, this presumption only serves to exacerbate the power imbalance between the healthcare professional and the patient (Richardson et al., 2017). Therefore, it is imperative to remember that we, as healthcare professionals, have our own culture and should reflect on how our experiences and cultures affect those around us so that we can humble ourselves to see our own privileges and to come up with ways to administer the best health care regardless of subtle prejudices.

**Cultural Humility**

Wherein cultural competency tends to leave the impression that health care professionals focus on learning about the culture of the patient or client, cultural humility directs us to view everyone, including ourselves, as “bearers of culture” (Allan & Smylie, 2015, p. 35). Cultural humility, attributed to Tervalon & Murray-Garcia (1998), is an active engagement in a lifelong process. A process of "committing to an ongoing relationship with patients, communities, and colleagues that requires humility as individuals continually engage in self-reflection and self-critique” (p. 118).
Culturally humble practice involves a shift from an *expert* model to the *student/learner* model, prioritizing lifelong self-reflection, recognizing and challenging power imbalances, and mutually-engaged community collaboration and advocacy (Tervalon & Murray-Garcia, 1998). Cultural humility addresses many of the criticisms against cultural competency. Culturally humble practice, for example, explicitly acknowledges power differentials between provider and client and asserts that “problems do not often arise from a lack of knowledge but rather the need for a change in practitioners’ self-awareness and attitudes toward diverse clients” (Tervalon & Murray-Garcia, 1998, p. 118).

While other disciplines are beginning to use the term cultural humility, social work literature is limited, with only one article (Ortega & Faller, 2011) reporting an explicit cultural humility focus required for child welfare workers engaging with families. However, Ortega and Faller (2011) suggest that a cultural humble approach be taken as a complement to cultural competence whereas, more recently, the literature is calling for cultural humility as an alternative rather than a *complement* to cultural competency (Fisher-Borne, Montana Cain & Martin, 2015).

In the next section I will review how I have come to understand this through a self-reflexive process that I acquired during my MSW coursework and in my previous practice as a social worker. This process is an important one.

**Self-Reflexivity and Cross-Cultural Allyship**

As a third-generation settler on this land, I attempted to understand why such a large and pervasive gap continues to exist in health care depending on what your social
and physical location is. However, it is also challenging to understand why so few opportunities exist to engage in dismantling health disparities. Why is it that political will is failing to address the unfair and unjust health disparities that exist in our communities? Providing quality care and improving health outcomes are intrinsic to one’s choice to become a healthcare professional in the first place. Yet, there is a growing body of evidence that suggests that discrimination within health institutions persists towards people who are elderly, less educated, women, minorities, and live in poverty (Smye & Browne, 2002) and that healthcare organizations are key contributors to the poor health of Indigenous peoples living in Canada (Allen & Smylie, 2015; Government of Manitoba, 2014; Government of Manitoba, 2017; Government of Saskatchewan, 2009; TRC, 2015a; TRC 2015b). One solution to the problem of inequities in health care is maintaining conscious awareness and a critically reflexive stance. By examining our implicit biases, power, and privilege, we are more prepared to avoid promoting stereotypes that are harming others on a large scale (Baskin, 2016).

In 1998, new research emerged that changed the landscape of how we understand stereotypes, biases, and prejudice as a natural human phenomenon. Project Implicit, developed in conjunction with Harvard University, released the Implicit Association Test that found that the majority of North American society (up to 70% in some categories) carry negative, unconscious stereotypes when it comes to the three categories of race, age, and gender (Banaji & Greenwald, 2013). This free, computerized test continues to be available and maintains its relevance three decades later.

The Implicit Association Test reveals that the biases or prejudices we attribute to certain groups of patients or clients do not necessarily reflect the behaviour or beliefs of
bad people, but, rather, normal people that are reflecting the biases and messages of the society in which they live. Healthcare providers are simply part of the larger society; we are products of the culture in which we grew up. The research shows that, even though we might be personally committed to principles of equality, human rights, and reconciliation; without conscious awareness and critical reflection, when we meet someone that fits that stereotype, we will treat them differently and can be largely unaware that we did so (Banaji & Greenwald, 2013). In fact, if someone were to be asked whether they treated a particular patient differently than another patient, they might respond, honestly, that they had not. It is important to raise awareness levels around this subject so that all healthcare professionals become aware of this tendency that is considered normal, that we all have as human beings.

It is important to note that behaviours directed towards certain groups do not arise from an explicit set of beliefs, but rather, through unconscious processes. Conscious critical awareness, or what is referred to as self-reflexivity, is crucial for healthcare professionals to avoid perpetuating health inequities and biases that keep us from understanding one other because of differences (e.g. socio-economic or cultural) (Baskin, 2016). The commitment to reflective practice, or self-reflexivity, must be taken very seriously. Because of where I locate myself (in terms of social location, described earlier), it is important to engage in an intentional and conscious, critical investigation that questions the way I understand the healthcare system.

Boutilier and Mason (2017) suggest that it is through questioning one’s experiences and developing new understandings and knowledge that we will have the greatest
impact on our current or future practice and, arguably, the future of our healthcare system. Arguably, a commitment to the promotion of culturally humble practices and culturally safe interactions in health care also holds the most significant promise for transforming our healthcare system.

However, it is important to note that the quest to bring cultural humility and a self-reflexive approach to the workplace never ends. These principles emphasize continuous, explicit attention to our implicit biases. The self-awareness necessary to become more culturally humble in both our personal and professional lives often begins by engaging in the process of allyship (Baskin, 2016). The journey of allyship begins by working on oneself and engaging with the concept of self-reflexivity, or critical self-reflection. This is a critical component to engaging in cross-cultural allyship since it involves both the conscious and non-conscious use of power in relationships.

From a theoretical perspective, according to the pedagogy of Brazilian popular education theorist Paulo Freire (1970), the development of a social consciousness, which is the precursor to social change, really begins with a close examination of one’s own experiences and one’s location within an unjust social and political environment. In some instances, such as my own, this examination will include a focus on whiteness, and how white people experience privileges and the widespread assumption that anyone should have equal access to these privileges. This refers to the assumption that, for example, if Indigenous peoples do not enjoy the same level of rights as the rest of us then they are partly responsible for this.
Self-reflexivity encourages us to begin by looking at our family history and current social location. Examining one’s own privilege is crucial to becoming an ally. It involves considering one’s collective identity and values by which one lives and how these may impact service users (Baskin, 2016). This also includes the uncomfortable process of acknowledging the privileges we receive from systems that oppress Indigenous peoples and our complicity in allowing this system to continue. Ultimately, we must have a strong awareness of self and feel secure in who we are when we engage in cross-cultural relationships, but we must also maintain a stance of humility. No degree of cultural competency, or knowledge of someone else’s culture, will provide us the self-awareness necessary to provide culturally safe care.

One way to ensure that particular groups are not left out of, or sidestepped in, conversations about racism and health care is by a willingness to hear stories of their lived experiences. For several years, the Saskatchewan Health Authority has moved toward valuing the existence of what is referred to as first-hand accounts of lived experiences. An opportunity to explore how cultural safety is experienced for patients and clients accessing health services was one of the early components of this field practicum. At the Public Health Observatory, many staff believed that senior leaders in the Saskatoon Health Region were aware that some service delivery areas had been struggling to provide culturally safe care and that the existence of lived experiences of cultural safety was notably missing.

Prior to hosting this field practicum, the Public Health Observatory fielded requests for examples of lived experiences of cultural safety, or un-safety, throughout the
health system. Cultural safety, as previously discussed, “refers to relationships and environments which are perceived to be inoffensive and non-violent” (Wilson et al, 2013). It involves a feeling of psychological safety when accessing services or receiving care (Baskin, 2016; Ball, 2008, NCNZ, 2011).

The Saskatoon Health Region, in its commitment to reconciliation (2016b), stated that, as an institution, it would seek to improve health experiences and outcomes as a result of providing more culturally safe health care. In order to tackle this issue of improving health experiences for Indigenous peoples specifically, we need to think about decolonizing health care so people receiving health care are treated based on their symptoms or ailments rather than their social standing or culture. To do so, it will be important to explore how colonial values and practices are embedded in and maintained by our health system – and how the majority of initiatives aimed at addressing health disparities, racism, etc. have not acknowledged or targeted the colonial roots of the system (Dahm, 2014).

**Decolonizing Health Care**

Due to the structures of inequality within our society, many people who have been minoritized (e.g., Indigenous, small ethnolinguistic and religious groups) or who do not identify with Western cultural standards, find healthcare systems inaccessible. They cannot access certain treatments because of mistrust of the system and lack of accommodation to their culture. Dahm (2014) reminds, “healthcare should be a universal right – it needs to be decolonized and made accessible to all” (p. 1).
Moving forward with the conversation regarding how health inequities are faced by Indigenous peoples in Canada it is important to explore how colonial values and practices are embedded in and maintained by our health system – and how the majority of initiatives aimed at addressing health disparities, racism, etc. have not acknowledged or targeted the colonial roots of the system. This requires engaging in an intentional, decolonizing approach that acknowledges the historic and ongoing colonization of Indigenous peoples. This approach involves exploring how colonial values and practices are embedded in and maintained by our health system – and how the majority of initiatives aimed at addressing health disparities, racism, etc. have not acknowledged or targeted the colonial roots of the system.

Indigenous populations in Canada suffer from a variety of health disparities, including higher rates of infant mortality, higher rates of diabetes and other chronic diseases, greater prevalence of tuberculosis and other communicable diseases, as well as a shorter life expectancy compared to non-Indigenous Canadians (Baba, 2013). In Saskatoon, the PHO reported that over 45% of the (Indigenous) peoples living in the City are living in poverty and likely in areas of highest deprivation where health inequities are most persistent (SHR, 2014). It is important to note that health inequities are not exclusive to Indigenous groups, but it was the population whom I chose to focus on for the purposes of the field practicum research.

We now know that health inequities are the result of exposure to varying qualities of living and working conditions, which have come to be known as the social determinants of health (Raphael, 2017). The legacy of colonization is ingrained in the identity of Indigenous peoples and continues to act as a social determinant of health today. At the
core of the colonization experience is the loss of culture, which includes the loss of language, land, resources, spiritual practices, and political and personal autonomy (TRC, 2015a; TRC, 2015b).

The Truth and Reconciliation Commission (TRC) Final Report and subsequent recommendations (TRC, 2015a; TRC, 2015b), inspired the Saskatoon Health Region to make health equity a priority. The Health Equity Position Statement (SHR, 2016a) is one example of the SHA responding to the TRC “calls to action” and of SHA’s commitment to reconciliation.

However, we already knew, well before the TRC report(s), that the impact of colonization is experienced in all areas of Indigenous lives: education, cultures and languages, health, child welfare, the administration of justice, and economic opportunities and prosperity (TRC, 2015a; TRC, 2015b). It was an important gesture for the former SHR to issue a stated commitment to both health equity (SHR, 2016a) and reconciliation (SHR, 2016b). Yet, in order to move in the right direction, the healthcare system is going to require even greater constructive action if the provincial health authority is serious about addressing the ongoing colonialism that has had, and continues to have, destructive impacts on First Nations and Métis people (TRC, 2015a; TRC, 2015b).

Recognizing how culture and ethnicity affect social position in our society through factors such as racism, discrimination, oppression and poverty, is an important step to decolonize our healthcare system. It is also necessary to acknowledge, accept responsibility, and welcome reconciliation and decolonization in both our personal and professional lives.
Theoretical Framework

It is important to begin with a reminder and reflection that each and every one of us are shaped by a range of experiences and factors including our first homework assignment, our first argument, our family and friends, our social standing, etc. The same is true of each client and patient being cared for in health care. Unfortunately, many of them have also experienced traumatic events that have molded them into the people they are. These traumatic experiences must not be discounted but seen as factors that have led these people to sometimes react to certain situations with fear, hesitation, or even anger. Knowing how to address people who have suffered trauma is another critical requirement for providing equitable and culturally safe health care.

Defining Trauma

According to leading trauma expert, Dr. Sandra Bloom, “to understand what trauma does, first we need to understand what it is” (1999). Trauma is commonly defined as an experience that is too overwhelming to cope with (Greaves & Poole, 2012). When a person experiences a traumatic event, it can have a lifelong devastating impact on the person’s sense of self, safety, attachment, relationships, ability to regulate emotions, and physical or mental health (Burke-Harris, 2018; Greaves & Poole, 2012; van Dernoot Lipsky, 2009).

Trauma is a public health problem that we can now connect back to the costly individual and social problems that confront all areas of health care (Bloom & Farragher, 2011; Bloom & Farragher, 2013; Burke-Harris, 2018). In fact, many of the inequities we see when it comes to populations experiencing chronic health problems, child maltreatment, school failure, crime, family conflict
and breakdown, mental illness, substance use, homelessness, interpersonal violence, community violence, and job performance issues are all correlated with experiences of childhood adversity and trauma (Burke-Harris, 2018). Exposure to direct trauma is so prevalent that service providers should naturally assume that many of the people to whom they provide services have, in one way or another, been affected by trauma (Manitoba Trauma Information and Education Centre, 2013).

More specifically, trauma theory refers to a set of physical, cognitive, and psychological responses to a particular horrifying, or traumatic, event (Regehr & Bober, 2005). As a result of this exposure, a person could experience intrusive thoughts or dreams, avoid stimuli that might trigger memories or experience autonomic arousal or hyper-vigilance (Burke-Harris, 2018; Figley, 1995; Regehr & Bober, 2005). Trauma theorists indicate that people are unique in their responses to traumatic events and a considerable amount of literature has been devoted to the subject of resilience, protective factors and the disparity in the severity and duration of individual responses to the same traumatic event (Baskin, 2016; BC Centre of Excellence for Women’s Health, 2013; Bloom & Farragher, 2011; Bloom & Farragher, 2013; Burke-Harris, 2018; Figley, 1995; Greaves & Poole, 2012; Harris & Fallot, 2001, Manitoba Trauma Information and Education Centre, 2013; Regehr & Bober, 2005; Saakvitne & Pearlman, 1996; Sexton, 1999; van Dernoot Lipsky, 2009; Versola-Russo, 2005).

A considerable amount of time during my MSW coursework was spent exploring trauma theory as the basis for a different set of causal notions for individuals experiencing mental health and addictions issues. Trauma theory, of course, allows us to understand that the individual and the environment (or experiences) are deeply interconnected when it comes to health outcomes or overall well-being (Bloom, 2016). So, when I began to plan for my field practicum, I was intentionally looking for areas within the healthcare system promoting a different type of truth about health outcomes, one that was much more informed by trauma.
Trauma-Informed Care

Trauma Informed Care (TIC) was first introduced in inpatient and juvenile mental health facilities (Bills & Bloom, 1998). It is an organizational model that presumes that everyone (from staff to clients) has experienced trauma (Harris & Fallot, 2001). Put simply, it involves the shift from understanding trauma survivors from the lens of what’s wrong with you to one of what happened to you (Manitoba Trauma Information and Education Centre, 2013). A dimension model of TIC was developed by Harris and Fallot (2001) and remains one of the most saliently discussed in the literature (Bloom, 2016; Bloom & Farragher, 2011). This model suggests that trauma-informed environments should be characterized by five guiding principles: safety, trustworthiness, choice, collaboration, and empowerment (Harris & Fallot, 2001).

A trauma-informed organization understands the impact of trauma on staff and clients and is responsive to their respective needs by embedding this knowledge within the organization’s policies, procedures, and practices (Bloom & Farragher, 2011). According to the Manitoba Trauma Information and Education Centre (2013), in their comprehensive resource referred to as The Trauma Toolkit, a trauma-informed program, organization, or system as one that will: a) realize the widespread impact of trauma and understand potential paths for recovery; b) recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system; c) respond by fully integrating knowledge about trauma into policies, procedures, and practices; and d) seek to actively resist re-traumatization (p. 16).

All systems, all organizations, and all people need to become trauma informed. For more than a decade, healthcare professionals have been successfully utilizing a trauma-informed approach and this approach has been met with positive responses from clients and patients (Bloom & Farragher, 2011; Bloom & Farragher, 2013; Burke-Harris, 2018; Greaves & Poole, 2012; Manitoba
Trauma Information and Education Centre, 2013). It is because of this approach that we have become much more comfortable asking others about their trauma histories and others are feeling safe enough to speak out about recent or ongoing traumatic experiences. It is important to note that a trauma informed approach does not require providers to ask or request others to disclose their trauma histories.

For those in professions at the receiving end of these disclosures, engaging in trauma work with survivors comes with a cost. Unfortunately, failing to deal with the impact of supporting people who have experienced trauma can lead to short- and long-term emotional and physical health concerns, strains on interpersonal relationships, substance misuse, and compassion fatigue for all helpers (Baskin, 2016; Bloom & Farragher, 2011; Bloom & Farragher, 2013; Manitoba Trauma Information and Education Centre, 2013; Regehr & Bober, 2005; Sexton, 1999; Van Dernoot Lipsky, 2009; Versola-Russo, 2005). The next section of this document will review the literature available on the impact of supporting people who have experienced trauma as a healthcare professional, and how to recognize the signs of compassion fatigue.

**Is Trauma-Informed Enough: Compassion Fatigue and Burnout**

As a result of the landmark Adverse Childhood Experiences (ACE) Study in the 1990’s, the prevalence of exposure to traumatic events continues to become more widely understood (Felitti, Anda, Nordenberg & Williamson, 1998). In the ACE Study, the researchers studied seven categories of experiences. Three of the seven categories were labeled as abuse - psychological, physical, or sexual; and four categories were labeled household dysfunction - substance abuse (alcohol and drugs), mental illness (depression and suicide), violence against mother or stepmother (wife-beating, threats), and criminal
behavior (imprisonment) (Felitti, et al., 1998). The intent of the ACE study was to document the relationship between childhood experiences and important medical and public health outcomes in adults. Results from the seventeen-item survey revealed that as many as one in six people reported having had experienced four or more adverse childhood events (Felitti, et al., 1998).

Because the exposure to ACE’s is so common, healthcare professionals are likely to have their own histories or experiences that “consciously or unconsciously, for good or ill, collide and intersect with those of the clients in their care” (Bloom & Farragher, 2013, p. 20). When this happens, the providers within the healthcare system are inadvertently replicating the very experiences that have been so traumatic for their clients or patients (Bloom & Farragher, 2013).

After being repeatedly exposed to story after story about traumatic experiences, health and social service care professionals are also at risk of emotional exhaustion and what is commonly referred to as compassion fatigue and/or burnout (van Dernoot Lipsky, 2009; Versola-Russo, 2005). Compassion fatigue is most commonly understood using the original definition from Figley (1995), which describes this phenomenon as the emotional and physical erosion that results from caring for people who have been traumatized over a period of time. The term burnout is often used to describe a feeling of hopelessness or exhaustion that an individual feels that prevents them from doing their job effectively (Figley, 1995). These impacts have also been referred to as empathic strain, countertransference, secondary traumatic stress, or vicarious traumatization (Bloom & Farragher, 2011; Regehr & Bober, 2005). These terms are often used interchangeably, and there is a
lack of general consensus on which is the most accurate as they tend to represent different things to different people.

Regardless of the label, there are serious implications for every healthcare discipline working with survivors of trauma, from housekeeping and maintenance to nurses, physicians, and social workers (Bloom & Farragher, 2013; Van Dernoot Lipsky, 2009). We rarely acknowledge the effects trauma has on us, our teams, and our organization as a whole; and the toll of traumatic human experiences and intense emotions is being felt by many of us in health care. It has become routine to see patients waiting in the hallways of hospital emergency departments, leaving one to wonder if they will ever be admitted to the appropriate ward. This also has an impact on those working in those hospital departments and wards.

Within trauma literature, possible factors that make an individual more susceptible to compassion fatigue include a personal history of trauma, lack of adequate supervision or lack of supervisor support, higher number of years of experience on the job, repeated exposure to trauma, lack of job satisfaction, and large caseloads of trauma survivors (Sexton, 1999; van Dernoot Lipsky, 2009, Versola-Russo, 2005).

Ultimately, to sustainably work with traumatized people in a trauma-informed way, it is important to understand the impact of the work on the workers. To accomplish this, the healthcare system must take steps to create an environment in which workplace vicarious traumatization and burnout are acknowledged as legitimate byproducts of working in trauma-saturated, under-resourced, and constantly changing health care settings, and where compassion fatigue is viewed as an organizational problem and not simply as
an individual one (Bloom & Farragher, 2011; Bloom & Farragher, 2013; Burke-Harris, 2018).

As noted in the beginning of this report, it was my interest in trauma-informed principles during my MSW coursework that led me to seek a field practicum opportunity wherein I could explore and apply leading practices in order to promote and support trauma-informed principles within the healthcare system. This literature review informed the final activity in my field practicum: the development and delivery of a presentation for managers and senior leaders in public health addressing the topic of how to build a trauma-informed team. The next section describes the material and discussion included in a PowerPoint presentation focused on constructing trauma-informed groups that was delivered on the final day of this field practicum.

**Building Trauma-Informed Teams**

Just as the encroachment of trauma into the life of patients and clients is an insidious process, so too is the impact of trauma work within organizations. Bloom and Farragher (2013) use the metaphor of an earthquake and how it might cause the foundation of a building to become unstable even while the building is still standing, seemingly intact; for how organizations (e.g. healthcare) can unwittingly reorganize themselves because of chronic, repetitive stress. The cognitive and emotional foundations of entire teams can become compromised over time because of the strain and can become, what Bloom & Farragher refer to as “trauma-organized systems” or “trauma-organized staff” (2013, p. 19).

When an institution becomes trauma-organized, people accessing our health, mental health, and social service environments are more likely to experience feelings of
unsafety, helplessness, and confusion (Bloom & Farragher, 2013). Staff describe these environments as punitive, overwhelming and demoralized (Bloom & Farragher, 2013). The organization itself is described as crisis driven, mission-less, and fragmented (Bloom & Farragher, 2013).

Fortunately, in the last few years there has been a notable shift towards educating staff on the importance of trauma-informed practices, in particular, with frontline healthcare staff. This is a much needed and commendable addition to our healthcare delivery system. However, as a result, we are seeing more helpers exposed to more details of trauma. As a result, more and more frontline staff members are being vicariously traumatized and experiencing burnout during their careers (Bloom & Farragher, 2011; Bloom & Farragher, 2013; Burke-Harris, 2018; van Dernoot Lipsky, 2009). Currently, in healthcare, frontline staff members are able to articulate direct or vicarious experiences of trauma but, unfortunately, our system hasn’t been able to provide an adequate degree of support for the shift to becoming trauma-informed. As noted above, Bloom & Farragher (2013) describe an organization that fails to change their policies, procedures and practices when engaging in this work as trauma-organized rather than trauma-informed.

My practicum supervisor has spent the past few years educating staff about trauma-informed care principles and the prevalence and impact of vicarious trauma. During my short time at the Public Health Observatory, requests for my practicum supervisor and/or myself, to deliver presentations on trauma-informed approaches came from hospital nursing units, Mental Health and Addictions Services, and the Royal University Hospital Ethics Committee. Requests even came from external community partners such as the Saskatoon Public School Division and the University of Saskatchewan. Knowing all
these requests were unlikely to be carried out during the course of my field practicum, we chose to focus my attention on one presentation which was requested at the site of my field practicum: Population and Public Health.

Deciding to take on this presentation relates directly back to the learning objectives for this practicum. When selecting a field practicum in the area of macro social work practice, I was hoping to advance my facilitation skills through the involvement of the education of others. During my practicum I was able to witness the delivery of several of these trauma-informed presentations by my practicum supervisor before I was inspired and confident enough to attempt the delivery of my own.

When a request came in from a manager of Population and Public Health just over halfway through my practicum, to present on the subject of “building trauma-informed teams”, my professional associate and I decided that I would spend a significant portion of my remaining time at the PHO preparing for the presentation. The decision to do this was related to both my passion to achieve a richer understanding of trauma and because the presentation would also allow me to meet my learning goal of increasing my public speaking skills.

Preparation for the presentation began with a review of the literature in the area of trauma theory and trauma-informed practice, from both its origin (Figley, 1995) and current, best-practice standards (BCCEWH, 2013; Bloom & Farragher, 2013; Burke-Harris, 2018; Greaves & Poole, 2016) to describing how we can understand staffing concerns such as high sick-leave usage, workplace conflict, and compassion fatigue from a trauma-informed perspective. In summary, the content of the presentation included a brief introduction to trauma terms and concepts, the prevalence of adverse childhood experiences
(ACE’s), and the basic principles of trauma-informed care as they apply to managers and supervisors.

The presentation also featured recommendations from the literature on meaningful ways to identify, prevent or manage the burnout of Population and Public Health employees through self-reflexivity, self-care, mindfulness, and formal and informal debriefings. The one-hour presentation designed and facilitated for managers and senior-level employees of Population and Public Health took place on the final day of my field practicum. It was well attended, resulted in rich questions, and inspired a group discussion afterwards that actually needed to be cut short due to time restraints.

Given the recent changes to our healthcare model, leadership, and organizational structure, my field practicum correlated perfectly with a growing appetite to create a new, more trauma-informed, system of care. Fortunately, many of the institutions that are intended to address the needs of our population, such as health care, child welfare, mental health, and education, are developing an awareness of the complex effects of trauma (Bloom, 2016). However, while a training event or presentation can signal the beginning of change:

… actually changing paradigms that underlie the way we act toward one another, what and whom we value, and how we change our social norms requires far more extensive, uncomfortable, and consistent realignment over time and will only happen if leaders at all levels embrace and model change in their own attitudes and behavior… substantial, universal, deeply rooted change is unlikely to occur unless the components of the human services delivery system become aligned with one another. (Bloom, 2016, p. 386-287)
Managers and other health leaders are recognizing the need to transform and realign our healthcare system to one that embodies the frameworks of health equity, cultural safety, and trauma-informed practice. However, during this field practicum, it became obvious how much the system lacks support for, and understanding of, how and where to put these frameworks into action. To accomplish this, an extensive investment of time and resources will be required. It also demands a change in very basic assumptions about the impact of trauma, role of culture in health and health care, biases and prejudices of healthcare professionals and root causes of existing health inequities. The reflexivity required to change these basic assumptions is not a comfortable, or even welcomed, task for many people.

It is my opinion that these three frameworks correlate and complement one another quite well when working to create an institutional environment that is safe and supportive for both patients and healthcare providers. In order to better understand how to create an environment that aims to help both patients and healthcare providers, I became involved in a project that focused on the experiences of Indigenous peoples and their healthcare experiences. The intention was to explore and learn, from those with lived experience, about where the health care system is flawed and what changes need to take place.

**Storytelling Project**

Following a consultative process, including an ethics exemption from the University of Regina Research Ethics Board (see Appendix A for ethics exemption), I spent a significant portion of my field practicum designing and implementing this small qualitative project titled *Indigenous Experiences of Cultural Safety in the Saskatoon Health Region*. Through the collection of stories, this project sought to highlight changes, improvements, and/or problems in the healthcare delivery system. The intention was to document
first voice experiences with the healthcare system that might be used for staff education, reflection, policy change, program development, or to guide practice. Using stories was a natural choice since stories are the framework of civilization, and they are integral to Indigenous cultures and world views.

**Storytelling Framework**

Stories are considered universal. Through the work of Dr. Brenè Brown, we are reminded that people everywhere tell them and listen to them (2010). Of course, each of us do this in a variety of unique ways. We tell stories to understand ourselves, our communities, and the larger world (Brown, 2010). Regardless of what format is used, or how stories are produced or shared, when a story surrounds a universal theme it becomes one that we can connect with on a deeper level. A story might be culturally specific in terms of language, local references and details; but when a story addresses universal themes such as love, illness, death, or parenthood, this adds to its power (Brown, 2010). When the storyteller addresses a universal theme we are more likely to connect to the story and make meaning from it.

The Story Center, an organization that supports individuals and organizations in using storytelling and participatory media for reflection, education, and social change, believes that stories told in a first-person voice can create a further level of intimacy (2018a). Aspects of personal truth, such as detailed descriptions of what one has gone through, convey a sense of honesty that engages the listener in a way that third-person reporting, research, and statistics cannot (Story Center, 2018a). We are more likely to empathize, remember, and be persuaded by the story if it is told from first-person point of view.
One thing that is crucial to conveying a sense of honesty is the degree in which we convey personal vulnerability with the story (Brown, 2010). Contrastingely, stories that come across as public service announcements or seem too polished have less of an impact. It is for this reason that I made the decision to compose this report largely from a first-person narrative. The intersectionality of having been (and continuing to be) a front-line healthcare professional myself, yet having to receive, witness and explore the entrenched prejudices of the healthcare system, inspired me to turn to the literature around self-reflexivity. Furthermore, I would like to remind the reader that the concept of cultural safety demands this as well. Being able to unpack what cultural safety is (and could look like) for the healthcare system demands that we take a self-reflexive approach and interject ourselves, our social location, and our own prejudices and unconscious biases into our personal and professional lives. It is for this reason that I am interjecting so much of my own voice into this writing.

Another aspect noted in the literature surrounding storytelling is dismantling the idea that individuals alone are responsible for the health challenges they or their communities face (Raphael, 2017; White & Epston, 1990). Receiving stories from participants that were able to be traced back to the structural or systemic factors involved in their experiences receiving health care was of particular interest to me during this project.

The intention, when presenting or sharing the final product, was to highlight certain details, scenes, or emotions in the stories so that the reader or listener would be able to situate those experiences within broader social, cultural, and political contexts in Saskatchewan. To accomplish this, narrative questioning techniques were used to engage the participants throughout the storytelling process.
Narrative Questioning Techniques

The narrative metaphor draws our attention to the fact that people are often able to make sense of their lives through stories (Brown, 2010; Freedman & Combs, 1996; Morgan, 2002; White & Epston, 1990). Freedman (2014) shares that “… although each of us has a huge number of experiences, only a few of these become the stories that shape us and through which we shape our lives” (p. 20). Rather than focusing on a single story, narrative questioning techniques can help people develop multiple stories through the deconstruction of problematic stories, through telling and retelling preferred stories, and through witnessing the stories of others.

The narrative approach seemed to be the most appropriate fit for this project because there was no particular research question in mind. However, it is important to note that during these interviews a narrative therapeutic approach was not used. The intention was simply to facilitate an atmosphere that allowed for the disinhibited retelling of their experience(s) based solely on the interviewee’s interpretation of them.

Within narrative therapy, there are what is referred to as questioning techniques that were useful in guiding my role as the interviewer. When utilizing the questioning techniques the intent is to look for opportunities where people might begin to separate themselves from their problems, or externalize the problem (Morgan, 2002; White & Epston, 1990). During the course of these interviews there were several opportunities where clarification was requested or empathy was delivered around certain parts of their story that were clearly problematic (e.g. treatment by healthcare staff in the Emergency Department). During these opportunities, I empathized with their experience but inquired about their opinion as to why this might have happened and about whether they believe that
teenage Indigenous women would experience the same thing today, for example. As much as I was curious about their experiences, I was also concerned about the complexities and root causes of the social order within the healthcare system that led to these experiences. The next step was finding people who wanted to share their stories with me; and so the recruitment process began.

**Recruitment and Consent**

I extended an invitation to receive stories from members of the Aboriginal Peoples Patient and Family Advisory Council within the Saskatoon Health Region. This Council is made up of representatives with lived experience; either former patients or clients, or family members of patients or clients. Patient and Family Advisory Councils exist throughout the SHA and formed as a result of a movement to provide more patient and family-centred care (Government of Saskatchewan, 2009).

Experiences of culturally (un)safe health care are by no means exclusively experienced by Indigenous peoples in Saskatchewan; however, patient and family advisory groups have not yet been formed for other cultural or linguistic minority groups. I chose to focus on the Indigenous population not only because there is already a process in place to provide honorariums for their time and access to potential interviewees, but also because the mandate of this group is to contribute to the quality and improvement of the healthcare system by acting as community experts and sharing their lived experiences. I knew these lived experiences would likely evoke strong emotion and require immense vulnerability on the part of Indigenous volunteers so making sure I collected these experiences in an ethical way was very important to me.
Ethics and Storytelling

Prior to scheduling any interviews, it was necessary to navigate the process of submitting this project to the University of Regina Research Ethics Board (REB). Up until this field practicum, my only experience developing consent forms had been following the clear guidelines of the REB. For this project’s consent form, I was faced with the task of combining plain language to depict the storytelling nature I was looking for while ensuring it met all the requirements for the REB. Ultimately, an ethics exemption was granted because the project was deemed to be a quality improvement project instead of research. Not being required to go through the full ethics review process granted me the time I needed to feasibly carry this activity out during my practicum placement.

Keen attention to ethics during this project was important to me as a registered member of the Saskatchewan Association of Social Workers and the respect I have for my professional Code of Ethics (CASW, 2005). As researchers, or as “researcher-storytellers”, a term used by Brown (2010) to describe her style of data collection, it is also of utmost importance to uphold the safety and dignity of storytellers and audiences worldwide. Facilitators and partners must be transparent with storytellers, about workshop and story distribution goals and methods. This transparency must be “woven through the life of a project”, from storyteller recruitment to story distribution (Story Center, 2018b, p. 3).

The group selected for my project, Indigenous people who had been patients or clients of the healthcare system, was invited to share culturally safe or un-safe experiences they may have experienced when accessing health services. Wanting to be respectful, I sought the counsel and support of the First Nations and Métis Health (FNMH) Department at the Saskatoon Health Region. It was very important to me to ensure cultural
protocols were honoured regarding the collection and sharing of this information. Through the guidance provided by my practicum supervisor and FNMH, the consent form I designed included intentional language that was more storytelling-friendly and less colonized research jargon. For example, instead of the heading “design”, I chose “how do I share my story?” Instead of “confidentiality”, I chose “how will you make sure my story is protected?” Instead of the “right to withdraw participation”, I chose “what if I no longer want to be involved with this project?” Above all, I wanted to ensure that participants knew that consent would be viewed as a process, not as a one-time activity, because the experiences I was asking them to share with me would likely be unpleasant to recall.

Generally speaking, the conditions for ethical practice described by the Story Center (2018b) are similar in many ways to the University of Regina’s guidelines from the Research Ethics Board that I paid close attention to during this project. One of the major differences, because the Story Center specializes in digital storytelling, was in the discussion of image ethics and how to treat photo and video materials during the collection of stories. However, this project did not collect any digital material. The next decision was about finding a technique that could help both my participants feel more in control of their stories while also giving me the chance to witness, through intentional listening, how our healthcare system has impacted their lives.

**Design**

When a difficult, perhaps even traumatic, experience is shared, the listener (or researcher) intentionally bears witness to the other person’s pain. Narrative questioning
techniques were used for the participants of this project while they described their culturally unsafe experiences in the healthcare system. This approach provides a sense of agency and control while telling stories about situations wherein the participants typically had little or no control (Morgan, 2002; White & Epston, 1990).

Narrative therapy, a form of therapy developed in the 1980s by Michael White and David Epston, involves questioning techniques that respect the agency and dignity of the person telling the story. In this type of therapy, the client becomes the expert of their story as only they know their own life experience that intimately (White & Epston, 1990). During narrative therapy sessions, the client would never be blamed for their problems and would also be encouraged not to blame anyone else. Instead, during the process of narrative therapy, the point is not to identify and assign blame to anyone or anything, but rather, to acknowledge that problems emerge in everyone’s lives due to a variety of factors often outside of one’s control (White & Epston, 1990).

The interview techniques used during the collection of these stories drew from this form of therapy and it seemed particularly appropriate given the prevalence and likelihood of receiving stories that could attach blame to a healthcare system or colonial structure that was responsible for it. As noted in the introduction of this report, the negative experiences of many people accessing healthcare services must be viewed not as an individual problem, but a symptom of the breakdown of the social order and therefore a problem for the entire community (Bloom, 1999).

How and when the stories gathered as part of this project would be shared or would reach senior leaders was unclear; however, both my supervisor and I agreed that these were stories worthy of capturing. Given my multimedia / videography background,
we originally sought to pursue a documentary-style project that allowed us to link these important experiences with the faces of our community. Under the counsel of staff from First Nations and Métis Health, the idea to approach the Aboriginal Peoples Patient and Family Advisory Committee with a multimedia video project was rejected. This was unsurprising to me, as a student and outsider to this group, and I respected that this was something that should happen only after a relationship and trust is formed.

The idea of using a brief, audio-recorded approach to interviews was agreed upon. As an internal quality improvement project, standard research processes were not utilized. With regards to data collection, the intent was not to belabour the process, so transcribing the interviews verbatim was not necessary. Instead, I was to review the audio and any handwritten notes I took and highlight any quotes and statements that stood out for me. At the time, I imagined these stories, or data, would be compiled into a document or used in some way for staff education, reflection, policy change, program development, or public health practice. At the time of writing, it was/is still unclear how or when the Saskatchewan Health Authority might be able to use these stories within their work. Feeling particularly passionate and excited to begin, I was ready to connect with my participants.

**Findings**

Armed with a tape recorder and permission from FNMH, I set out to find my first story. In a coffee shop in Saskatoon I met the first person to be interviewed, a woman, who I will refer to as “Alice”. The conversation lasted almost 90 minutes. Although not a residential school survivor herself, Alice was the child of parents who were. The story she shared with me began with her experience of falling ill with tuberculosis at only three
months old. Alice would spend nearly two years in a hospital in Fort San, Saskatchewan, a facility designed to quarantine children and adults with this disease. Upon her release, her parents were unable to care for her, stating the reason as the impending birth of a sibling. She was sent to live with a foster mother until the foster mother died when she was ten years old. It was not an easy life for her after that. Alice shared, “I went home to my real parents and absolutely hated it. I was going to run at sixteen but I thought if they could find me they could still take me back… So when I turned seventeen, I knew they couldn’t touch me so I came up here [to Saskatoon].” (personal communication, November 26th, 2017).

It was shortly after this that Alice found herself pregnant and having to take care of herself again. She had been working as a nanny for a family and, fortunately, had a place to live. At five months pregnant, she believed it was important to go to the hospital because she wasn’t feeling movement from the baby. What she recalled was a lack of compassion from the hospital staff that she attributed to her being a young, Indigenous woman. She had no family there to support her or to advocate for her needs. She was 17 years old when her daughter was stillborn. She shared with me how poorly she was treated by the nurses, both during active labour as well as following the loss of her daughter. She was not given the choice to hold her daughter following the stillbirth. She questions whether it was the protocol of the nurses at that time (30 years ago) to not offer the choice to hold the baby, or whether it was because she was a teenage Indigenous girl with no family or support of a partner. In her own words, she shares,

I had a little girl. Lost her when I was five months pregnant… when they took her
out, I never got to see her… She died when I was carrying her. I remember when I was leaving, just really feeling beaten down after they took her. I remember looking at the floor and there was a black bag on the floor, a garbage bag. And now, when I think about it, I always think, I wonder if that was my baby girl….They didn’t listen to me at all; that’s just the way it is, you know? When you grow up on the reserve and you’ve grown up being told that you don’t have choices or anything, you just take what’s dished out. Especially if you are young. I was young. I was 17. Back then people stared at you because you were so young. You feel really lonely. They make you feel low because they’re just gawking at ya, you know? I often wonder if it’s even a whole lot different now… (personal communication, November 26th, 2017).

When I replay the audio recording of our interview and reflect on what both of these experiences must mean for Alice, I empathize with how traumatic they must have been for her. I find myself curious about how much healing has had to occur for her to be able to sit with me, a complete stranger, and tell me these things; how she wrestles with trusting that she will receive compassionate care if she ever needs to go to a hospital again.

Although it was not the focus of my project, I was grateful when she alluded to how she was able to heal from the loss of her daughter when she was invited into a hospital room by her niece, who also had to endure the delivery of a stillborn daughter. It was by being in that delivery room and ensuring that her niece got to hold and say goodbye to her daughter that Alice found a small element of peace. “Now they wrap the babies up”, she said. “They give you the baby. I never had that opportunity. That was closure, being
able to hold her baby… I’m glad things have changed some” (personal communication, November 26th, 2017).

A couple of weeks later I would receive the story of my second participant, whom I will call “Bernice”. Instead of describing her own experiences, she shared with me the experiences of her son and a close friend. She wished to share with me her impression of the care her son, a young Indigenous man, received after a serious health complication had him admitted to the hospital several times. However, Bernice cautioned me that she recognized that she might have a clearer, more objective picture of it in a few months because it was all very recent. She indicated that she believed she would be more “emotionally settled” if we could meet again in six months to share any additional thoughts about his experience (personal communication, December 12th, 2017). Unfortunately, I knew this was unlikely to be the case and I found this challenging as a listener of her story and as a practicum student.

At the beginning of our interview, she shared with me her gratitude to the hospital staff and the surgeon that saved her son’s life following an invasive surgery. But she was frustrated that it even had to come to needing such a life-threatening operation. She shared with me how her son went to a Saskatoon hospital six times and was either treated superficially or turned away. She said,

What I have a problem with, is I feel that they [healthcare professionals] didn’t do a critical analysis of his situation to say, ‘why is this kid, who’s not a chronic addict, or drug addict or have cancer, coming back here six times for pain in this area? What’s the core root problem of his pain?’ That really gets me angry when I think about it. And I think about it, had they dealt with it then, this kid wouldn’t
have turned septic months later and almost be dead. (personal communication, December 12th, 2017).

It was her opinion that her son was turned away because he was presumed to have been presenting with stomach issues similar to what one might have if one drank excessive amounts of alcohol. He had been unemployed during this time and living with her, but drugs or alcohol played no part in his symptoms. It was, however, often the subject of the questions being asked by the emergency department staff.

Although I was able to get a good sense of the negative experiences that some Indigenous peoples have had to face, I still found myself limited because of time restraints of the practicum, the small number of participants, and not feeling as though I used the narrative technique to its full extent.

**Discussion and limitations**

Hearing the stories that these participants shared with me was a profound and humbling experience. The questions that I asked of them were very open ended and were based on narrative interviewing techniques and perspective. Expressing narratives through story sharing can be an empowering process as it allows people the space to make meaning of their experiences (Story Center, 2018a).

Regrettably, I was only able to schedule and complete two interviews prior to the end of my practicum placement. By the time I had identified all of the details in this project and completed the ethics review process, half of my practicum hours had already been completed, and I still had much I wanted to accomplish. Each of the two participants shared two stories of culturally unsafe experiences for a total of four stories. All four of these stories referenced inpatient care experiences.
For example, although the choice of utilizing narrative questioning techniques allowed the storytellers to have their culturally unsafe healthcare experiences heard, I am less convinced that the participants were able to discover meaning or find healing through the experience of participating in this project. In narrative therapy, reaching this point with clients is known as *re-authoring* or *re-storying*, and it occurs when clients explore their own experiences to find alterations to their story or create a new one (White & Epston, 1990).

Upon reviewing the audio recordings from these interviews and upon further reflection, I believe this project would have been aided by allotting time during the field practicum to conduct subsequent interviews with each participant, giving both the storyteller and myself time to process the story and come up with clarifications or connections from their experiences to the sociopolitical structure of the healthcare system. Admittedly, after listening to their stories for the second and third time, there were questions or conjectures I would have come up with during additional conversations had there been an opportunity to do so.

The experiences that were shared with me have been transcribed into written form. At present, the transcriptions are being stored at the Public Health Observatory. The intended use for the stories was never identified so, unfortunately, the culturally unsafe experiences the two participants shared with me have not been shared with others. The possibility still exists to incorporate quotes or themes from their stories into staff training, leadership team meetings, or orientation material. Should the stories be used, it
is important to note that the consent form (Appendix B) indicated that my practicum supervisor, or representative from the PHO, would offer the opportunity for the participants to validate the transcription to ensure accuracy.

**Future Directions for Health Care**

The next sections will give an overview of how health care services and systems can be improved by looking at the benefits of equitable, culturally safe, and trauma-informed health care; while also suggesting tangible ways to advance health care so no more people have to worry about how they’ll be treated the next time they need to see a doctor or other health professional.

**Equitable and Culturally Safe Health Care**

The responsibility for supporting culturally safe care is shared among individuals, professional associations, regulatory bodies, health services delivery systems and accreditation organizations, educational institutions, and governments. Accreditation bodies and educational institutions can support culturally safe care by adopting standards of care that encompass the principles of cultural safety (NAHO, 2008).

Allan and Smylie (2015) argue that ensuring access to culturally safe care is an important component in improving the health of all Canadians, in particular, Indigenous peoples. Adopting a culturally humble approach to health care can benefit individuals, providers, and healthcare systems. When care is experienced as culturally safe, patients respond better to care and are less likely to be adversely affected by their experience accessing health care services. This is not a novel concept; it has, in fact, been around for over three decades. In 1986, The World Health Organization issued the Ottawa Charter for Health Promotion that urged the health sector to:
… move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate [that] is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components. (World Health Organization, 1986, p. 3)

In addition to transforming into a more equitable, culturally safe health system, the benefits extend far beyond the patients and clients accessing services. Equitable and culturally safe care can benefit healthcare providers as well. According to the National Aboriginal Health Organization (2008), this type of care can lead to increased confidence and job satisfaction and may even help to increase retention rates for health professionals in rural and remote communities. This has implications for preventing compassion fatigue and burnout, as well as our ability to deliver services and to build teams that are trauma-informed (Burke-Harris, 2018). Trauma-informed teams are understandably linked to trauma-informed health care, and the more effort these teams put into making health care equitable and culturally safe, the better for all involved.

**Trauma-Informed Health Care**

Incorporating trauma-informed care or practice is another strategy I found worthy of exploring during this field practicum as a means of transforming our health system to one that addresses health inequities and improves overall health outcomes. To do this in a sustainable way will continue to require vision and action beyond a personal understanding of trauma, toxic stress, and their effects on our communities (Bloom, 2016; Burke-Harris, 2018). It requires administrative and policy responses to recognize the costs and
challenges of doing this work and the support necessary to counteract those costs (Bloom, 2016). If frontline healthcare professionals are not supported by leaders committed to incorporating trauma-informed practices and the training required to do so, they may find it difficult to sustainably engage in trauma-informed service delivery (Bloom, 2016). Ultimately, this results in increased staff experiencing burnout, vicarious traumatization and other negative effects.

Whenever the framework of trauma-informed practice is being adopted, adequate and ongoing trauma training and education must be provided (Bloom, 2016; Burke-Harris, 2018). In addition to basic information about the prevalence of trauma, staff need the space to critically reflect on how their paid work affects them, their ideas and attitudes about self-care, and the prevention and treatment of burnout and compassion fatigue (Baskin, 2016; van Dernoot Lipsky, 2009).

Fortunately, management teams in healthcare settings are beginning to recognize this and are increasingly offering trauma-informed staff in-service training opportunities similar to the one I facilitated during this practicum. During my field practicum, I was inspired by the inroads being made by my supervisor alone, and the interest of others at Population and Public Health in continuing to learn and talk about this more. These inroads gave me the hope that my practicum was worth doing because other people could see a need for changes to the healthcare system as well.

**Conclusion**

When my field practicum began, I was eager to engage in a variety of activities under two primary frameworks promoted by the Public Health Observatory: health equity and cultural safety. Unfortunately, I found that very few opportunities existed that were
tangible enough for me to join during my four months with the organization as a graduate level practicum student. Fortunately I was able to create my own unique field practicum opportunity and even find the courage to share some of what I had learned and was passionate about with other healthcare professionals in the form of a presentation to supervisors and managers within Population and Public Health.

Another one of the challenges I faced was working at the placement two to three days a week. Due to my personal life circumstances as a mother of two children under the age of three, this was a decision that was best for my family. This was also a challenge because I felt disconnected at times from the work environment. Although I feel the time I was on site was stimulating and even though I bonded with several members of the team, I would have felt more connected having been at my placement full time. Fortunately, I concluded my practicum feeling grateful for the two projects I was able to complete and greatly inspired by the important work the PHO continues to champion through advancing the principles of health equity and cultural safety.

This final report revealed what it looked like, for me, to engage in macro social work practice from a critical and reflexive stance and how I was challenged in my understanding of cross-cultural allyship in an attempt to apply and steward health equitable, culturally safe, and trauma-informed principles in a healthcare setting. The opportunities - ranging from my inclusion in team huddles, consultations, presentations and projects - afforded to me by the Public Health Observatory made this possible in a unique way, resulting in a greater understanding of the importance of engaging in potentially transformative, decolonizing, organizational change.
References


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BUILDING EQUITABLE, CULTURALLY SAFE, & TRAUMA-INFORMED


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Sexton, L. (1999). Vicarious traumatization of counsellors and effects on their...


Appendix A

Research Ethics Board Exemption

<table>
<thead>
<tr>
<th>PRINCIPAL INVESTIGATOR</th>
<th>DEPARTMENT</th>
<th>REB#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christina Anderson (Chair)</td>
<td>Faculty of Social Work</td>
<td>N/A</td>
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</tbody>
</table>

**TITLE**
Experiences of Cultural Safety/Un-Safety in the Saskatoon Health Region

**REVIEWED ON:**
October 10, 2017

Thank you for submitting the summary and consent form for your proposal: Experiences of Cultural Safety/Un-Safety in the Saskatoon Health Region. It has been determined that this project does not require REB Review as per article 2.5 of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, which states:

"Quality assurance and quality improvement studies, program evaluation activities, and performance reviews, ... used exclusively for assessment, management or improvement purposes, do not constitute research for the purposes of this Policy, and do not fall within the scope of REB review."

Note that although exempt from Research Ethics Board review, all aspects of the study must be conducted in an ethical manner. If there are significant changes to the methodology or the research question, please notify the Research Ethics board as review may be required based on the proposed changes.

Sincerely,

[Signature]

Ara Steininger
Research Compliance Officer
Research Office

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Please send all correspondence to:
Research Office
University of Regina
Research and Innovation Centre 109
Regina, SK S4S 0A2
Telephone: (306) 585-4771
research.ethics@uregina.ca
Appendix B

Participant Consent Form

Project Title: EXPERIENCES OF CULTURAL SAFETY/UN-SAFETY IN THE SASKATOON HEALTH REGION

Project Team: Christina Anderson, Graduate Student
Faculty of Social Work, University of Regina
charterc@uregina.ca | 306-262-2358

Erin Beckwell, Practicum Supervisor
Public Health Observatory, Population & Public Health
erin.beckwell@saskatoonhealthregion.ca | 306-655-3448

Kara Fletcher, Academic Supervisor
Faculty of Social Work, University of Regina
kara.fletcher@uregina.ca | 306-664-7380

What is this project about?

- Cultural safety refers to a person’s feeling of safety (or lack of safety) as they interact with the health care system. As an Indigenous Patient and Family Advisor and member of the Aboriginal Peoples Patient and Family Advisory Council [APPFAC] with the Saskatoon Health Region, we are interested in your thoughts and experiences about the treatment of First Nations and Métis persons in health care. By sharing your story, this project hopes to highlight successes or possible changes or problems that exist in the Saskatoon Health Region.
- This project is being completed as a partial requirement of students’ practicum experience at the Public Health Observatory.

How do I share my story?

- You will meet with Christina [student] at a time and place that works for you and at a location where privacy can be maintained. This should take 1 or 2 hours of your time.
- With your permission, your story will be audio-recorded to make sure that your words are being shared accurately. Christina may also take some handwritten notes.
- Quotes or statements may be pulled from the audio recording of your story and used for staff education and reflection or to inform policy, programs, or public health practice.
• There will not be specific questions you need to answer. Please share any part of your story you feel comfortable with.

Are there risks involved?

• It can be upsetting to remember some of your experiences as a patient. If you feel upset at any point when sharing your story, you may end the interview.
• Contact information for local support services will also be available, in the event you feel you need to talk to someone as a result of your interview with Christina.

How will sharing my story benefit me?

• You will not receive a direct benefit by participating in the interview. However, you may find your participation rewarding in terms of contributing to a project aimed at improving the experience as a First Nations and Métis persons receiving health care services.

Will I be paid for my time?

• As a Patient/Family Advisor who is helping improve our health care services, you will be paid the regular honorarium from the APPFAC fund.

How will you make sure my identity is protected?

• All of the information you share will be treated with respect and kept confidential. This means that the audio recording and other materials will be kept secured, either in a locked office at the Public Health Observatory or on a computer or device that is protected by a password. No one except Christina, Erin and Kara will have access to the audio recording or other materials.
• Whenever stories are used, it will be done in a way that does not identify the storyteller. Because we may use direct quotes when sharing your story, you will have a choice to create your own pseudonym (false name) or allow us create one for you.
• Because you have been selected from a small group of people it is possible that you might be recognized by others based on what you share. Any part of your story that might identify you (places, health information or outcomes, etc.) will be removed or changed as much as possible. However, we cannot guarantee that other people may not be able to recognize you from what you said.

What if no longer want to be involved with this project?

• Your participation in this interview is voluntary and you may withdraw for any reason without an explanation or penalty of any kind. Whether you choose to join this project or not will have no effect on your membership with the APPFAC or as a Patient and Family Advisor.
• We will begin compiling stories in early December, 2017. Once information from your story has been reviewed and is being compiled with the stories of others, it will be impossible to remove your information from the project.
Where do I go if I have questions about the project?

- If you are interested in reviewing the quotes selected to be transcribed from your story, to ensure it describes what you meant to say, this can be made available to you.
- To obtain copies of the written or audio collected, please contact Erin Beckwell via telephone or email address listed on page 1 within 60 days.
- This project received an REB exemption from the University of Regina Research Ethics Board (October 20th, 2017).

SIGNED CONSENT (completed by participant)

__________________________________________  ____________________________  ____________
Name of Participant               Signature               Date

Your signature below indicates that you have read and understand the information provided. I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the project. A copy of this Consent Form has been given to me for my records.

__________________________________________  ____________________________
Student Signature               Date

ORAL CONSENT (completed by student)

I have read and explained this Consent Form to the participant before receiving the participant’s consent, and the participant had knowledge of its contents and appeared to understand it.

__________________________________________  ____________________________  ____________
Name of Participant               Student Signature               Date

A copy of this form will be left with you, and a copy will be taken by the student.
Appendix C

Cultural Safety Principles

Protocols
- Show respect – Ask permission/informed consent
- Seek cultural knowledge – Ask questions
- Demonstrate reciprocity – Learning goes both ways
- Engage community accompaniment – Find allies, mentors in community of practice

Personal Knowledge
- Hone critical consciousness of social location/power
- Who are you? Cultural affiliations, professional persona
- Introduce yourself in terms of your cultural identities

Partnerships
- Engage in relational practice founded on authentic encounters
- Share knowledge vs. ‘telling’
- Collaborative problem solving vs. expert/authority
- Strengthen mutual capacity vs. one-way ‘delivery’
- Co-construct ways to move supports into place

Process
- Ensure equity and dignity for all parties
- Negotiate goals and activities
- Talk less, listen more

Positive Purpose
- Build on strengths
- Avoid negative labelling
- Ensure confidentiality
- Be accountable
- Do no harm
- Make it matter: Ensure real benefits