COTBC
Quality Practice Webinars
Today’s session will start shortly

Indigenous Cultural Safety in Your Practice – Part Two
With Dr. Alison Gerlach and Jenny Morgan, RSW
Welcome

Thank you for attending

• Participants are placed on mute.
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Indigenous Cultural Safety In Your Practice

Kathy Corbett
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Indigenous Cultural Safety In Your Practice

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Director of Indigenous Health, Women and Families at BC Women’s Hospital and Health Centre
Cultural competency is a process not an event; a journey, not a destination; dynamic, not static...

– Josepha Campinha-Bacote
Q: Is there a risk that occupational therapy may be experienced as oppressive?

You asked...

There was a display about how Europeans did not see the value of Indigenous cultural activities (e.g., carving and potlatches) as they were not ‘productive’ in the newcomers' minds. I was struck by how similar this colonialist attitude was to some of the founding ideas of our profession (at about the same time in history). Residential schools sought to teach children ‘appropriate’ activities and habits.

Any thoughts on this observation?
“Occupational therapy in its present dominant form – its knowledge, theory and practice are culturally situated in Western spheres of shared experiences” (Iwama, 2007, p. 24).

“When we unwittingly foist these ideals onto our clients, our therapy becomes vulnerable to the larger dynamics of social injustice and oppression (Iwama, 2007 (p. 23).
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‘Turning the lens inwards’
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Above the surface = *Our* taken for granted/routine ways of *thinking about and doing occupational therapy*.

Below the surface = *The underlying values, beliefs and assumptions that guide/inform our clinical reasoning and practice.*
Developmental screening/assessments: “a test, pass and fail and something to be worried about as opposed to helping build on strengths”.

“Formalized assessment and goal setting intervention kind of approach; it doesn’t work, and it doesn’t feel authentic for me either because I know the relationships won’t thrive like they’re not natural” (Gerlach, 2015).
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Q: How to work towards continuing cultural competency?

You asked...

[What] if there is limited knowledge on someone's cultural backgrounds? Are there any guidelines?

Any suggestions on how to build relationships in a community or with a new client?
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Suggestion...

Respectful, non-judgmental, and empathetic interpersonal relationships and relational processes are more important than the content of any intervention tools or programs (Grace & Trudgett, 2012; Lynam, et al 2010).
“What was successful was I just created the space to listen. There was lots of reciprocity in the relationship... I was equally learning from her [the mother] about her culture and family and the challenges that she was facing and she was learning from me” (Gerlach, Browne, & Suto, 2016, p. 6).
Q: How should I respond when I see abuse toward Indigenous people at work, or in a public place?
Invalidating Encounters

• Dismissal by health care providers: feeling that health concerns were not taken seriously.

• Transforming one’s self to gain credibility: feeling the need to change appearance and behavior to obtain credibility and legitimacy.

• Marginalization from the mainstream: feeling of being on the ‘outside’ and ‘intruding’.

• Situations of vulnerability: vulnerability in health care system are a common consequence of Residential School abuse when survivors have to expose their bodies for examination.

• Disregard for personal circumstances: socioeconomic pressures (Browne & Fiske, 2001).
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Affirming Encounters

✓ Actively participating in health care decisions: being able to speak openly through shared knowledge and power

✓ Receiving exceptional care: health providers with outstanding ability to convey a caring attitude

✓ Development of a positive, long-term relationship with a health provider: significance of provider-patient relationships grounded in mutual respect and trust (Browne & Fiske, 2001).
Q. How do we navigate the child welfare system?

You asked...
Who should we work with in the community when we feel from our own understanding that a child may be neglected, knowing that our present system does not always have the patience or funds required to work with as opposed to against the family. My feeling is that many forms of neglect are not intentional, but systemic if that makes sense.
Poverty misconstrued as ‘willful parental neglect’ is the primary reason for Indigenous children being removed from their family homes (Sinha, Trocmé, Fallon & MacLaurin, 2013).

The under-funding, current structure, and ‘protection first’ agenda of the child welfare system is failing many Indigenous families and children in BC and across Canada (Representative for Children and Youth, 2013).
Some options to consider:

- transparency - duty to report *with* not about family;
- guide/support family in accessing basics – food; housing; healthcare; childcare etc;
- know who is available in the neighbourhood or community (social and professional network) to provide ongoing support – the manager of the health centre; Aboriginal IDP or SCDP consultants for advice?

Intersectoral community network tables (Lynam, et al 2010).
DECLARATION of COMMITMENT

CREATE A CLIMATE FOR CHANGE
- Articulating the pressing need to ensure cultural safety within First Nations and Aboriginal healthcare services in BC.
- Opening an honest and convincing dialogue with all stakeholders to show that change is necessary.
- Forming a network of influential roles and networks to promote collaboration and the benefit of embedding cultural humility and safety in BC healthcare services.
- Leading the creation of a vision for a culturally safe healthcare system and developing strategies to achieve the vision.
- Supporting the development of work plans and implementing through available resources.

ENGAGE & ENABLE STAKEHOLDERS
- Communicating the vision for culturally safe health systems to key stakeholders, leaders, and policymakers.
- Opening and promoting discussions on the need for cultural humility and safety on behalf of all stakeholders, partners, and clients.
- Advocating and championing change by example.
- Measuring and communicating progress.
- Tracking, evaluating, and publicly recognizing accomplishments.

IMPLEMENT & SUSTAIN CHANGE
- Empowering healthcare organizations and individuals to innovate, develop cultural humility, and foster a culture of cultural safety.
- Allowing organizations and individuals to raise and address problems without fear of reprisal.
- Leading and enabling successive waves of actions until cultural humility and safety are embedded within all levels of the health system.
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My Commitment to Cultural Safety and Humility:

www.fnha.ca  @fnha  #itstartswithme  #culturalhumility

Q: How can my organization support cultural safety?

Ask...

- How many Indigenous families are accessing your programs and services?
- How are Indigenous families represented in your organization’s decision-making (e.g. on the Board)?
- How can your organization/program create spaces in which Indigenous knowledges on health and wellbeing are viewed as equally credible and valued and where Indigenous practices, protocols, and cultures are respected, offered, and celebrated?
- How can power hierarchies with clients and between staff in your organization be flattened’? (Browne, Varcoe, et al., 2012)
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Q&A
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How can COTBC and other Colleges help?
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What has COTBC done so far?
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New Zealand example

2. Practising appropriately for bicultural Aotearoa New Zealand

You treat people of all cultures appropriately. You acknowledge and respond to the history, cultures, and social structures influencing health and occupation in Aotearoa New Zealand. You take into account Te Tiriti o Waitangi The Treaty of Waitangi and work towards equal outcomes for all your clients.

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In closing...

...It’s time for your final questions or comments.
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References


References continued...

