

Developing a Cultural Safety Intervention for Clinicians: Process Evaluation of a Pilot
Study in the Northwest Territories

by

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BSc, Dalhousie University, 2010

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Abstract

The purpose of this study was to (1) explore the experiences and perceptions of clinicians who participated in a pilot cultural safety intervention in the Northwest Territories and (2) to make recommendations to pilot intervention in terms of design, content, and delivery. Indigenous and process evaluation research principles underlined this qualitative research project. Data was collected through semi-structured interviews with eight clinicians who participated in the pilot intervention. Findings, identified through thematic analysis, reveal that participants were satisfied with many aspects of the pilot intervention, including key learnings, but also experienced challenges. Among these challenges were dominant discourses that suppress conversations about power and privilege. These research results will inform the sponsors of this project to further refine the pilot training model to enhance clinician learning and engagement. This study may be insightful to researchers and program developers in other jurisdictions.

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Dedication

For Sana'a.

Introduction

Over the last several years, the Department of Health and Social Services (DHSS) of the Government of the Northwest Territories (GNWT) has acknowledged the need to address Indigenous health inequities in the Northwest Territories (NWT) in part, by creating a culturally safe and respectful environment for Indigenous people (Government of the Northwest Territories, 2016). Cultural safety, a concept originating in Aotearoa (New Zealand), aims to address power relationships deeply-rooted in colonialism and racism that manifest within mainstream health care institutions through policies and individual practices. Central to the creation of a culturally safe and respectful environment is cultural safety training. Indeed, the Truth and Reconciliation Commission of Canada (2015c) implores all levels of Canadian governments to “provide cultural competency training for all health-care professionals” (p. 25) as a means to redress the legacy of colonialism and work towards reconciliation.

In the fall of 2014, the DHSS sponsored its first pilot cultural safety intervention for NWT clinicians. As this was a pilot, the DHSS was not primarily concerned with the efficacy of the intervention itself, but rather, how participants experienced and responded to the processes of the intervention. Given my existing research interest in cultural safety and the need to identify a research project, the DHSS extended the opportunity to assess this pilot intervention as my thesis research. The findings of this study will assist the DHSS to identify next steps and ways to improve on the pilot to optimize participant learning and engagement.

Statement of Research Purpose and Objectives

As the first DHSS sponsored cultural safety intervention that reflects the NWT context, this research reveal valuable information about the ways NWT clinicians respond to cultural safety training, including the challenges and supports required to enhance learning. Ensuring that

clinicians are fully engaged in learning about cultural safety is crucial, because if not meaningfully integrated, changes in attitudes and critical thinking will be limited (Thackrah & Thompson, 2013). On a broader level, this research may contribute to scholarship about ways to nurture cultural safety learning and uptake by clinicians, particularly those who are non-Indigenous. As stated by Kirmayer (2012), “there is a great need for research on the process of implementation and outcomes of culturally competent [safe] services and interventions” (p. 160).

This study has two primary objectives. The first was to explore the experiences and perceptions of clinicians who participated in a pilot cultural safety intervention sponsored by the DHSS of the GNWT. The second objective was to make recommendations about the pilot intervention in terms of design, content, and delivery. The research questions guiding the study were:

- *How do clinicians experience or respond to the design, content and delivery of the pilot intervention?*
- *What aspects of the pilot intervention were perceived by participants to be most relevant and applicable?*
- *How do participants perceive or experience the overall pilot intervention of agenda, timing, activities, and content?*
- *What improvements could be made to the pilot intervention to ensure an efficient, respectful, and engaging process?*

Background

Indigenous Peoples in the NWT. In the NWT, Indigenous peoples¹ represent a slight majority, comprising 51% of the total population (Moffitt, 2016). Approximately 44,520

¹ “Indigenous peoples” is a broad term that refers to the original inhabitants of Canada. Original inhabitants are generally categorized as First Nations, Inuit, and Métis. This study will refer to Indigenous peoples as residents in the NWT and, as a whole, in Canada.

residents are spread across 33 communities, which span a large land mass of 1.2 million square kilometers across the Arctic and Subarctic (NWT Bureau of Statistics, n.d., Moffitt, 2016). Indigenous peoples of the NWT represent the Dene First Nations, Inuvialuit, and Métis. The Dene people are the original inhabitants of the NWT region and consist of five groups (corresponding languages are in parentheses): Dëne Sųhné Yatıé (Chipewyan); Dinjii Zhu' Ginjik (Gwich'in); Sahtúot'ıne Yatı (North Slavey); Dene Zhatıé (South Slavey); and Tıchq Yatı (Tıchq) (Prince of Wales Northern Heritage Centre [PWHC], 2018). Inuit people are the original inhabitants of the Arctic, from eastern to western Canada. Those residing in the NWT and the Yukon are known as the "Inuvialuit". The three official Inuit languages of the NWT are Inuktitut, Inuvialuktun and Inuinnaqtun (PWHC, 2018). Finally, the ancestors of modern-day Métis people in the NWT made their way North in the late 1700s and settled around the regional centers of Fort Smith and Hay River (Northwest Territory Métis Nation, 2017). Métis in the NWT speak Cree (PWHC, 2018).

Indigenous Health in the NWT. Health outcomes for Indigenous peoples in the NWT resemble the rest of Canada; experiencing a disproportionate burden of ill-health when compared to the non-Indigenous population (Government of the Northwest Territories, 2017-2020). According to the Government of the Northwest Territories' Strategic Plan (2017 – 2020), "despite some improvements over time, there still remain significant disparities in the overall health status, compared to non-Indigenous residents" (p. 9). Available health data indicate disparities in health outcomes related to cancer (colorectal, cancer mortalities), tuberculosis, diabetes, and sexual transmitted infections, to name a few (Statistics Canada, 2016). Other available statistics demonstrating inequitable disparities relate to health behaviours such as heavy drinking and higher smoking rates (Statistics Canada, 2016).

A Case for Cultural Safety Training in the NWT. Research has demonstrated that Indigenous peoples in Canada commonly experience barriers to accessing health care, including racist and disrespectful treatment by health care providers (Wylie & McConkey, 2018; CBC, 2016; Allan & Smylie, 2015; Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008; Browne, 2005). Several studies describe how Indigenous peoples' health care experiences are shaped by an acute sense of self-consciousness and how they are perceived by providers (Browne & Fiske, 2001; Browne, 2005; Tang & Browne, 2008). Experiences of racism in health care settings are not uncommon in the NWT context. CBC (2018a, 2018b, 2016) news articles have detailed several cases in the past few years, including one that resulted in a death.

We now know that service providers' clinical encounters are shaped by wider social and historical discourses about Indigenous peoples that result in "Othering", racializing, and culturalism (Tang & Browne, 2008; Browne, 2007; Browne & Varcoe, 2006). These discriminatory acts have negative implications for the lives of Indigenous peoples, including emotional and social harm, a reluctance and reduction in utilization of health care services and non-compliance of treatment plans, which all together, can contribute to negative health outcomes, and in some cases, death (Lloy & McConkey, 2018; Loppie, Reading & de Leeuw, 2014).

Status of Cultural Safety Training in the NWT. This thesis expands on my undergraduate research, in which I examined the concept of cultural safety within Yellowknife, NWT medical clinics. Part of my undergraduate study involved examining the perspectives of health professionals who provide care to Indigenous peoples and the training they received to prepare them for this work. The results revealed that no information about Indigenous contexts or histories had been received prior to or during the tenure of their positions (Hall & Tirone,

2010). Since then, DHSS cultural safety training for service providers remains markedly absent. However, a review of the literature revealed that the NWT Aurora College nursing program incorporates many aspects of cultural safety in their curriculum, including content about racism, power and privilege, reflexivity, and post-colonial theory as well as taking students out on the land (Moffitt, 2016).

Overview of Pilot Intervention

Settings and Pilot Intervention. The NWT Health and Social Services system is operated by the GNWT and comprised of the DHSS and three agencies – the Northwest Territories Health and Social Services Authority (NTHSSA), Hay River Health and Social Services Authority (HRHSSA), and the Tłıchǵ Community Services Agency (TCSA). The DHSS is responsible for supporting the mandate of the Minister of Health and Social Services through the development of policies, legislation, and standards; establishing programs and services; financial management; and evaluation and reporting (Government of the Northwest Territories [GNWT], 2017-2020). The three agencies are operational branches and provide NWT residents with health and social services care and programs, including: in-patient services, specialist services, child and family services, mental health and addictions services, long-term care, diagnostic and therapeutic services (GNWT, 2017-2020). One territorial hospital is located in Yellowknife with two regional hospitals located in Inuvik and Hay River. Primary health care in smaller communities is often provided by community health nurses in health centres (Moffitt, 2016). In this thesis, the term “patients and clients” will be used where possible to align with the NWT health and social services strategic plan (GNWT, 2017-2020). However, in some cases “patient” or “client” will be used when referring to literature that uses such terminology.

In early 2014, the DHSS contracted a non-Indigenous, Northern-based (born and raised in the NWT) consultant to design and deliver a pilot cultural safety intervention/workshop for NWT clinicians. The contract resulted in a two-day pilot workshop for clinicians held October 22-23, 2014 at Cassidy Point, NWT (Cassidy Point is approximately a 25 minute drive outside Yellowknife). The pilot workshop titled, *Cultural Capabilities² Think Tank*, delivered sessions consistent with the concept of cultural safety and provided opportunities for participants' sharing and reflecting. Three additional facilitators assisted in the delivery of the workshop. The facilitators included two Indigenous Northern Knowledge Holders, one Indigenous physician from the South, and the non-Indigenous consultant who holds a PhD. The Indigenous Northern facilitators and non-Indigenous consultant provided contextual information about colonial history in the NWT whereas the Indigenous facilitator from South drew from a national research scope as it applies to cultural safety and racism and bias in health care. Clinicians were recruited by mass email sent by a DHSS representative (See Appendix A). In total, 15 clinicians attended the pilot intervention.

An overview of day 1 and 2 are provided in Table 1 and Table 2, respectively. These were formulated based off a GNWT internal summary report of the intervention by the consultant and a review of the PowerPoint presentations delivered by the consultant and the Indigenous physician from the South.

² Among many of the participants in this thesis study, the term “cultural capabilities” referred “to the skills, knowledge, behaviours and systems that are required to plan, support, improve and deliver services in a culturally respectful and appropriate manner” (Queensland Government, 2015, para 3).

Table 1: Overview of Day 1

Cultural Capabilities Think Tank October 22-23, 2014		
Day 1		
Session/Activity	Objectives	Additional Details
Welcome & Opening Prayer and Fire Feeding Ceremony	Indigenous ceremony to start workshop off in a “good way” and cleanse thoughts and intentions	- Held in teepee on site - Delivered by Indigenous facilitator
Lecture/Discussion History, Law, Policy & Social Suffering	- Indigenous peoples in the NWT; traditional territories and political agreements - Major policies, legal structures, events and social phenomena impacting Indigenous peoples in the NWT over the past 50 years - Colonization, historical trauma, theory of social suffering, settler colonialism, Indigenous resurgence and cultural safety and importance of these for the lived experience of Indigenous	- Delivered by non-Indigenous consultant - Lecture-style with PowerPoint

	peoples • Social determinants of Indigenous peoples' health	
Local Issues and Impacts	• Land use pattern and knowledge of Yellowknife area • Impacts of Yellowknife Giant Gold Mine on Yellowknives Dene land use, health, and ability to engage in social and cultural norms • Port Radium uranium mines • Community experiences and residential schools	• Delivered by Indigenous facilitators and non-Indigenous consultant • Lecture-style with PowerPoint by Non-Indigenous consultant
Indigenous Experiences of Colonization Impacts	• Personal experiences as healer drawing on cultural and land-based healing; personal and family impacts of residential school; cultural and social connectedness and relationship as a source of resiliency • Profound shift from being raised on the land; the pressures faced by those impacted by residential	• Delivered by Indigenous facilitators

	school experiences and the struggle to overcome the personal responses to that trauma; importance of land for healing	
Wrap Up		

Table 2: Overview of Day 2

Cultural Capabilities Think Tank October 22-23, 2014		
Day 2		
Session/Activity	Delivered By	Additional Details
Building Culturally Secure Clinical Practice	• Successful Indigenous health models and approaches • Understanding and acknowledging the issues: ○ Differences in quality health care access (research) ○ Definitions: discrimination, racism, systemic racism (implicit/explicit;	• Delivered by Indigenous facilitator from South • Lecture-style with PowerPoint • Participated via Skype

	intentional/unintentional) ○ Implications of stereotyping and discrimination • Knowledge building and skills for clinical practice: ○ Cultural safety ○ Critical thinking and reflexivity ○ Linking individual action to system wide change	
Small Group Discussions • Reflections and Feedback		
Closing Circle		

Preview of the Thesis

In total, this thesis is made up of five chapters. In Chapter 1, I present the literature as it pertains to cultural safety and training, including its significance to address Indigenous inequities in health and access to health care. Chapter 2 discusses the methodologies and research design employed to guide the study. In Chapter 3, the research findings are presented into five sections:

workshop content and delivery; learning environment; design and organization; overall feedback; and contexts. Chapter 4 provides a more in-depth discussion of the findings in relation to existing literature. Finally, Chapter 5 identifies the implications resulting from the study, including future research, limitations, and recommendations to the DHSS. This study provides contextual details related to clinician learning and engagement of cultural safety training in the NWT that may be insightful to other program developers in other jurisdiction.

Chapter 1: Literature Review

Social Determinants of Indigenous Peoples' Health Framework

A review of current Indigenous health disparities is important in order to highlight the urgent need to address these inequities. Equally important is to understand *why* and *how* health disparities manifest. A social determinants of health framework, particularly an Indigenous specific framework, is critical to this process.

Health, as defined by the World Health Organization (WHO), is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (2018). This definition demonstrates a shift from the traditional biomedical definition of health, to a more holistic one. Hence, efforts to address health disparities should target all realms of an individual’s wellbeing. The biomedical perspective refers to the dominance of western science; a discourse that targets disease as the single cause of ill health and assumes that health is restored once the disease has been treated (Wade & Halligan, 2004). Brassolotto, Raphael & Baldeo (2013) describe the ‘absence of disease’ perspective as decontextualized and depoliticized; in other words, an approach that ignores the social and political contexts in which people live. In contrast, the WHO recognizes that health is socially determined through a complex set of conditions referred to as the social determinants of health (SDOH), which are “the conditions in which people are born, grow, live, work and age – conditions that together provide the freedom people need to live lives they value” (Greenwood & de Leeuw, 2012, p. 381). The SDOH have been shown to influence health outcomes far more often than behavioural risks (Gleeson & Alperstein, 2006).

The SDOH include, but are not limited to: disability, early life, education, employment and working conditions, food insecurity, health services, gender, housing, income and income

distribution, race, social exclusion, social safety net, unemployment and job security (Mikkonen & Raphael, 2010). They represent “circumstances and environments as well as structures, systems and institutions that influence the development and maintenance of health along a continuum from excellent to poor” (Reading & Wien, 2013, p. 1). Inequitable social determinants of health create vulnerability for Indigenous peoples with limited resources to address ensuing health concerns (Reading & Wien, 2013).

Although the SDOH framework is critical for understanding health disparities among populations in general, Indigenous peoples have experienced, and continue to experience, unique contexts that impact the SDOH. These contexts are tied to social injustices resulting from a legacy of colonialism. In their report, *Health Inequities and Social Determinants of Aboriginal Peoples' Health* (SDIPH), Reading & Wien (2013) provide a comprehensive list of determinants at distal, intermediate, and proximal levels. *Proximal determinants of health* represent conditions most easily identified as influencing health outcomes. Also referred to as ‘surface determinants’, proximal determinants include: health behaviours, physical environments, employment and income, education and food insecurity. *Intermediate determinants of health* are also referred to as core determinants because they are the origins of proximal determinants and represent the systems driving proximal-level inequities. These determinants include: health care systems; educational systems; community infrastructure, resources and capacities; environmental stewardship; and cultural continuity. *Distal determinants of health* are deeply embedded within the historical, social, ideological, economic and political structures in which we live and include: colonialism, social exclusion and racism, self-determination, as well as cultural resilience and strength. Distal determinants are also known as root determinants because they influence determinants at the intermediate and proximal levels. As noted by Greenwood & de Leeuw

(2012), determinants at this level are the most challenging to change but are likely to result in transformation and therefore “yield the greatest health impacts and, thus, long-term change” (p. 382).

Due to the complexities of discriminatory experiences in health care and the underlying ties to colonialism and racism, I used the SDIPH as a framework for this literature review; beginning with the distal determinants of colonialism and racism (including social exclusion), followed by experiences in health care. Critical to a SDIPH approach and cultural safety, is to understand “how wider social and historical contexts continue to shape relations in health care and access to services” (Browne, 2007, p. 2166). The next section will demonstrate how distal determinants of colonialism and racism manifest themselves to create barriers for Indigenous peoples’ access to health care as it relates to racism and discrimination.

Colonialism and Racism as Distal Determinants

This section begins by providing a brief overview of colonialism and racism, followed by a discussion of Indigenous peoples’ experiences of racism and discrimination in health care settings. The examples provided are by no means exhaustive but represent key events that continue to take place within these settings.

In order to accurately capture the legacy of colonialism and racism within Canada, I draw upon three stages of history outlined in the final report of the Royal Commission on Aboriginal Peoples [RCAP] (1996). These stages situate Indigenous experiences on the lands currently known as Canada from pre-contact to assimilation. These stages include: separate worlds (stage 1); contact and co-operation (stage 2); and displacement and assimilation (stage 3).

Stage 1, *Separate Worlds*, serves as a reminder to position Indigenous peoples, families, and communities from a strengths based perspective rather than from a deficit approach. This

counters the pervasive discourse that Indigenous peoples are inherently “‘sick and defenseless’, [and a] burden to Canadian society” (Richmond & Cook, 2016, p. 2). This stage also provides insights into the knowledge systems and worldviews held by Indigenous peoples to this day.

Prior to 1500 and the immigration of Europeans, Indigenous peoples lived distinctly in a way that was “unintelligible to the West” (RCAP, 1996; Dion-Buffalo & Mohawk, 1992, as cited in Kuokkanen, 2000, p. 420). Indigenous societies thrived on values that can be understood as relational, collective, reciprocal, and respectful (Kovach, 2015). Reflecting a deep intrinsic connection and respect for the land and all creation, these values extend to the universe and Creator, which guide all aspects of life since time immemorial. My late uncle George Blondin (1997) explains a specific Dene worldview:

My ancestors found their own way of survival in our land. They established their own languages, culture, and laws, the same as any people on earth. The Creator put us in a country that was hard to survive in, but he also gave us great medicine powers to make our lives easier. (p. 20)

The knowledge of the environment, studied over generations, “formed the cornerstone of Indigenous way of life” (Richmond & Cook, 2016, p. 2). Indigenous knowledge is comprehensive, extensive, systemic; multidimensional which are inseparable from a holistic worldview (Battiste, 2005). The diverse worldview of holism helps explain the plurality of Indigenous knowledge that is gained through both tangible and subjective means. Mohawk scholar, Marlene Castellano (2000), identifies three common sources of Indigenous knowledge: revealed knowledge, traditional knowledge, and empirical knowledge. *Revealed knowledge* emerges from the spirit world and can present itself through dreams, visions, fasting, and ceremonies (Castellano, 2000; Simpson, 2001). Martin-Hill et al. (2008) emphasize the

importance of spirituality for Indigenous peoples, which serves as the foundation of Indigenous ideology and are manifested and affirmed in the practices noted above. *Traditional knowledge* refers to nation- specific knowledge passed down from preceding generations relating to creation, ancestors, and laws and protocols around cohabitation. *Empirical knowledge* speaks to the “science” employed by Indigenous societies in understanding their ecosystems, which include the process of careful observation from multiple perspectives over time (Castellano, 2000).

Indigenous peoples are largely purported as healthy prior to colonization. The self-determination of Indigenous peoples to live according to their values, beliefs, and practices explains why one of the “most important factors contributing to Indigenous health is a flourishing Indigenous identity” (Tomascik, Lavallée, Diffey, Lafontaine, Barnabe, Bourassa, Dignan, & Reading, 2014, p. 3).

Stage 2, *contact and cooperation*, represents the period in which Indigenous societies met Europeans where co-existence and cooperation ensued. Although not entirely conflict-free, Indigenous societies were recognized as independent nations and maintained rights to their ways of life and lands (Truth and Reconciliation Commission of Canada [TRCC], 2015a). This period was also characterized as one of reliance – where settlers sought assistance from Indigenous peoples to adapt to the foreign environment and alliance – where trading partnerships (i.e. fur trading) and military alliances were established (TRCC, 2015a; RCAP, 1996). Stephen Kakfwi, former Premier of the NWT, speaks to this time from a Dene perspective in an online educational video:

At first we were allies and friends to enable the first Europeans to survive in this country, to learn how to hunt and fish and grow things and have a healthy lifestyle, to becoming

allies in war as the French and English fought over the Americas and following that, once the wars were over, then there was an approach where Indian people, First Nations people were taken ‘out of the way’. (NWT Education Renewal, 2016)

Stage 3, *displacement and assimilation*, is where epistemological differences clashed as settlers sought Eurocentric priorities of land ownership, development, and the advancement of religion (Richmond & Cook, 2016). As Indigenous peoples were increasingly viewed as obstacles towards expansion efforts, a shift was made towards broad assimilation of Indigenous peoples between the late 1800s and early 1900s (RCAP, 1996). The Indian Act of 1876 remains to this day, an active race-based piece of legislation that gives the Government of Canada authority over the lives of Indigenous peoples in Canada (Richmond & Cook 2016; Allan & Smylie, 2015; Kirmayer, Simpson, & Cargo., 2003). Racism is a socially constructed ideology that certain racialized groups are inherently inferior to others, which often results in discrimination and oppression (Loppie et al., 2014; McGibbon & Etowa, 2009). Racist ideologies place Indigenous peoples near the bottom of a social hierarchy (Reading & Wien, 2013). Racism perpetuated colonialism, in which unfounded beliefs about what constitutes civilized and uncivilized societies, created justification for an assimilationist agenda and the oppression of Indigenous peoples (McGibbon & Etowa, 2009; Smith, 1999). “These are examples of socially engineered actions directed solely at the Indigenous race for the purpose of cultural genocide” (Tomascik, Lavallée, Diffey, Lafontaine, Barnabe, Bourassa, Dignan, & Reading, 2014, p. 3).

The Indian Act banned virtually all aspects of Indigenous ways of life from governing Indigenous identity to forced dispossession and displacement from traditional lands (Allan & Smylie, 2015). In 1920, the Indian Act was amended to enforce residential school attendance for

Indigenous children across Canada, which were in operations from 1830 to 1996 (Canadian Encyclopedia, 2018). Indigenous children endured various forms of physical, emotional, and sexual abuse. They were also forbidden to speak their languages or practice their cultures. This has resulted in a significant loss in the cultural identities of Indigenous peoples today. Over 150,000 Indigenous children were forced to attend residential schools, which the Truth and Reconciliation Commission of Canada (2015b) describes as an act of “cultural genocide.”

I did not know what was happening to me when some people took me from my loving parents. I was forced to move far away from my home to a place full of strangers. It was 1952, and I was only four years old. For six years, the government forgot me there. They just left me there without any explanation – to me, to my parents, to my brothers and sisters. Nobody said anything to me when I was left alone in residential school, year after year, summer after summer. (Blondin-Perrin, 2009, p. 1)

The purpose of this section was to provide an overview of Indigenous history in Canada from pre-contact to widespread assimilation efforts founded on an ideology of racism. The next section demonstrates how experiences in health care cannot be separated from the legacy of colonialism and racism.

Colonialism and Racism in Health Care

Not only do current health care discourses mirror the “morals and ethics upon which this structure is founded” (Richmond & Cook, 2016, p. 2) but they are also considered a determinant of “ill health for Indigenous peoples” (Nelson, 2012, as cited in Walker & Behn-Smith, 2015, p. 244). In other words, the manner in which health care is delivered and operationalized in Canada in present day contexts is a reflection of the inequitable history and traumatic relationship between Indigenous peoples and the Canadian state.

Research in Canada consistently demonstrates that Indigenous peoples face several barriers when accessing health care (Calvin, 2015; Hole et al., 2015; Reading & Wien, 2013; McGibbon & Etowa, 2009), including: accessibility and availability (e.g., geography), economic factors (e.g., transportation, cost of uninsured care, childcare), as well as culturally inappropriate models of care (i.e. biomedical), miscommunication, and racial discrimination at systemic and interpersonal levels (Walker & Behn-Smith, 2015; Hole, Evans, Berg, Bottorff, Dingwall, Alexis, Nyberg, & Smith, 2015; Reading & Wien, 2013; Davy, Harfield, McArthur, Munn & Brown, 2016; McGibbon & Etowa, 2009; Tang & Browne, 2008).

One way colonialism presents itself in the health care system is through the dominance of the biomedical model. Biomedicine or western medicine and its systems are based on science, empiricism, and rationality – all of which served as the basis for European expansion, and eventually colonialism. (Smith, 1999). Indigenous traditional healing and spiritual practices are in direct conflict with western medicine due to their lack of scientific rigour (Walker & Behn-Smith, 2015). Anderson & Kirkham (1998) contend that western biomedicine must be understood as part of capitalism, where “the priorities that drive the larger economic system filter down into institutional practices and, in turn, determine what each health professional is able to do” (p. 254). Capitalism can further be understood in the context of neoliberalism that favours free-market and individuality, where, in a health context, ‘service-users’ are deemed personally responsible for achieving good health (Murray, 2009). This mentality transcends western societies, in which good health is morally regulated and where individuals are blamed for their poor health status. Browne & Smye (2002) state that the western biomedical model tends to medicalize social problems and attributes these problems to lifestyle, behavioural, or cultural issues without regard for the complex relationships between history, social, economic, and

political factors.

The biomedical model of health care delivery is further intertwined with colonialism as research has demonstrated that Indigenous peoples avoid the health care system and providers because these interactions were painful reminders of negative residential school experiences (Jacklin, Henderson, Green, Walker, Calam, & Crowshoe, 2017; Walker & Behn-Smith, 2015; Hall & Tirone, 2010).

A lot of our [Indigenous] patients have a lot of fear [in the health care system] because of the abuse that they also have suffered themselves [in residential schools]. So this is what I'm saying you know you've got to be kind... take time with them. (Hall & Tirone, 2010, p. 13)

Racism and discrimination exert a powerful influence on the extent to which Indigenous peoples will access health services and achieve overall health inequities (Wylie & McConkey, 2018; Browne, Varcoe, Lavoie, Smye, Wong, Krause, Tu, Godwin, Khan, & Fridkin, 2016; Allan & Smylie, 2015). Evidence of negative staff attitudes and behaviours towards Indigenous peoples, including racialized stereotyping, prejudice, and discrimination, is widely documented through research, anecdotes, and grey literature (Wylie & McConkey, 2018; McNally & Martin, 2017; Allan & Smylie, 2015; Browne, Fiske, & Thomas, 2000; McGibbon & Etowa, 2009; Tang & Browne, 2008). "Numerous population surveys indicate Indigenous peoples perceive or experience high rates of interpersonal racism (up to 78%) within healthcare settings" (Indigenous Health Working Group, 2016). For example, in a diabetes study by Jacklin et al. (2017), one participant described presenting himself at a hospital with flu-like symptoms accompanied by a bloody mouth, which staff assumed was the result of "sniffing nail polish". Later, test results showed dangerously high glucose levels. The results of this study also demonstrate that other

participants were denied care or were provided inferior care. In fact, in addition to ubiquitous experiences of racism in health care settings, Indigenous patients believe that their Indigenous identity contributed to the dismissal of their health concerns by health care staff (Browne et al., 2000). Sadly, they report that, in some cases, they prepare themselves for this differential treatment (Browne et al., 2011). Jackin et al. (2017) describe the discrimination, stereotyping, and racism experienced by Indigenous peoples within health care as “reinforcing historical relationships” (p. E108).

Racism has been shown to have direct and indirect impacts on health outcomes and access to care. In terms of direct impacts on health, research demonstrates that experiences of racism have been linked to increased stress, hypertension, low self-esteem, and the use of drugs and alcohol as coping mechanisms (Reading & Wien, 2013; Galabuzi, 2004). When racism is experienced in health care settings, health is indirectly affected as Indigenous peoples are “reluctant to visit mainstream health facilities even when service is needed”, avoidance of treatment, non-adherence to treatment, and fear (Allan & Smylie, 2015; Hole et al., 2015, p. 1663; National Aboriginal Health Organization, 2008). Therefore, when examining Indigenous health inequities in health care and treatment, it is evident that many factors intersect and compound to create the current situation faced by Indigenous peoples.

Subtle yet powerful forms of racism are pervasive within the minds of mainstream Canadians and the popular media, which is evident in persistent stereotypes that Indigenous people are alcoholics, uncivilized, murderers, or ‘noble savages’ (McGibbon & Etowa, 2009; Kirmayer et al., 2003). Inaccurate conceptions and ill-informed beliefs about Indigenous peoples are linked to the Canadian education system that has failed to educate children and youth about our collective colonial history and its damaging effects on the Indigenous population (Vogel,

2018; Loppie et al., 2014). When institutions such as education and health care condone rather than challenge racist ideologies and practices, systemic racism ensues (McGibbon & Etowa, 2009). The prevalence of systemic racism reveals how colonial influences at the distal level have framed dominant discourses about Indigenous peoples.

Cultural Safety Training as a Strategy

It is widely accepted that in order to redress inequities in health outcomes and access to health care, health professionals must begin by learning about the social and historical contexts of Indigenous peoples' lives (Churchill, Parent-Bergeron, Smylie, Ward, Fridkin, Smylie, & Firestone, 2017; Truth and Reconciliation Commission, 2015b; Greenwood & de Leeuw, 2012; McGibbon & Etowa, 2009). "Knowledge that is constructed 'in context' that informs us how the social is embodied in individual experience provide insights, we argue, into how inequities are manifested in health, health care delivery and everyday social discourse" (Anderson, Rodney, Reimer-Kirkham, Browne). In other words, providing contextual knowledge and information about the realities faced by Indigenous peoples may act as a hedge against adopting harmful stereotypes (Greenwood & de Leeuw, 2012). This is supported by Brassolotto, Raphael, & Baldeo (2013) who contend that the "application of an individualized [decontextualized] discourse of health to public health work explains why we see such challenges to effectively addressing health inequalities" (p. 12).

Conceptualized by Dr. Irihapeti Ramsden, a Maori nursing researcher in Aotearoa, cultural safety was developed as a learning model to shift the field of nursing beyond concepts of cultural awareness, cultural sensitivity, and cultural competency to more critical understandings of how structural determinants, including colonialism and racism in health care, impact Maori health outcomes (Allan & Smylie, 2015; Dyck & Kearns as cited in Gerlach, 2012). Despite a

primary focus on Maori health within an Aotearoa specific context (historical, socio-political contexts), cultural safety has been widely adopted by other countries that share a similar colonial history involving Indigenous peoples, particularly in Canada and Australia (Yeung, 2016; Brascoupe & Waters, 2009).

According to Ramsden (2002a), there is a progression to achieve the outcome of cultural safety that begins with *cultural awareness*, followed by *cultural sensitivity*, and ending with *cultural safety*. *Cultural awareness* is the first step towards understanding that differences exist (Ramsden, 2002a). For Papadopoulos & Lees (2001), cultural awareness prevents practitioners from imposing personal beliefs and values. Others describe cultural awareness as training “to sensitise them [practitioners] to formal ritual and practice rather than the emotional, social, economic and political context in which people exist” (Gibbs, 2005, p. 358). *Cultural sensitivity* focuses on the practitioner and personal reflexivity to become aware of his or her beliefs that may impact others (Ramsden, 2002a). In terms of a research setting, Papadopoulos & Lees (2001) call matching an interviewer who has the same cultural background as the participant, a culturally sensitive act. However, Razack (1998) would argue that this approach simply “makes power relations invisible and keeps dominant cultural norms in place” (p. 9). Thus, the entire notion of cultural sensitivity reinforces the power difference in that the dominant structure will make some adaptations to accommodate difference; however, does not appear to address larger structural issues of authority.

Although not part of Ramsden’s (2002a) continuum, *cultural competency* is often used to bridge cultural sensitivity and cultural safety and is described as the skills and behaviours necessary to provide care in cross-cultural settings (Baba, 2013). However, there is a divergence of views about this. For example, according to Papadopoulos & Lees (2001), cultural

competency blends cultural awareness, cultural knowledge, and cultural sensitivity. Brach & Fraserirector (2000) contend that cultural competence “goes beyond cultural awareness or sensitivity” (p. 183) but critics of this approach claim that quality care cannot be reduced to mastering a set of skills (Baba, 2013). Finally, cultural competency is often confused and used interchangeably with cultural safety (Brascoupé & Waters, 2009) and is sometimes aligned conceptually with cultural sensitivity or with cultural safety (Varcoe & Browne, 2014). This trend was observed in many of the articles I reviewed, in which, despite espousing the tenets of cultural safety, the term “cultural competency” was used.

Finally, at the end of the spectrum is *cultural safety*. As an outcome, cultural safety is “based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care” (First Nations Health Authority, n.d. p. 5). Ramsden (2002b) locates *cultural safety* within critical theory, specifically post-colonialism as it examines how the organization of society revolves around power and class within institutions. Thus, *cultural safety* is concerned with social justice and the ways Indigenous peoples are impeded by the institutional power within health care, including misinformed and racist attitudes and behaviours exhibited by practitioners (Gerlach, Browne, & Greenwood, 2017; Browne, Varcoe, Smye, Reimer-Kirkham, Lynam, & Wong, 2009; Anderson et al., 2003; Ramsden, 2002a). Despite the fact that cultural safety roots itself within a non-Indigenous framework or paradigm, critical theory is considered an ally to Indigenous scholarship (Kovach, 2010). An example of a post-colonial perspective includes examining “healthcare discourses and related policies as political discourses that have the potential to both mask and perpetuate neocolonial practices in health care for indigenous people” (Browne & Smye, 2002, p. 31).

Varcoe & Browne (2014) assess the conceptualization of cultural safety not as a progression but rather on a critical continuum based on two elements: (1) the degree to which the concept examines issues of power dynamics and distal determinants of health (i.e. colonialism, racism, social exclusion) and (2) whether change is targeted at the individual level or as a collective responsibility at policy and practice levels. Cultural awareness and cultural sensitivity are located at the beginning of the critical continuum as they narrowly focus on change at the individual level, where staff are expected to become proficient in Indigenous cultures, the ability to identify the cultural “Other”, and in tolerating or managing those differences within the dominant health care system. This approach has “been criticized for homogenising and essentializing cultural and minority groups, and can have an unintended effect for confirming negative stereotypes or inventing new ones” (Pedersen, Walker, Paradies, & Guerin, 2011, p. 55). Cultural safety, at the other end, represents a critical approach that shifts attention beyond learning about Indigenous practices and cultures to focus on root determinants of health (Ward et al., 2016).

In terms of content, cultural safety training should reflect awareness of Indigenous history as well as ongoing racism Indigenous peoples experience within the contexts of colonialism (Delany, Doughney, Bandler, Harms, Andrews, Nicholson, Remedios, Edmondson, Kosta, & Ewen, 2018; Vogel, 2018; Allan & Smylie, 2015; Calvin, 2015).

As well, this training should include content about the SDIPH, such as barriers to accessing care. As the SDOH (and equity) are shaped by the distribution of power and resources that are controlled at a political level, learners must become sensitive to concepts of power.

Churchill et al. (2017) assert that cultural safety training should pay particular attention to “power, privilege, equity, settler colonialism, race and racism, and other structural forces into the

curriculum” (p. 9). Further, they contend that grounding content in “decolonizing, reflexive, anti-racist pedagogy” facilitates self-reflection, or reflexivity, which involves the examination of one’s underlying worldview, lived experiences, biases, assumptions, and privileges and power and how these factors influence one’s practice and the treatment of patients and clients (Allan & Smylie, 2015; Cushman, Delva, Franks, Jimenez-Bautista, Moon-Howard, Glover, & Begg, 2015; Downing & Kowal, 2011). This is often challenging and uncomfortable work as the examination of concepts related to privilege and power is often associated with whiteness (Durey, Taylor, Bessarab, Kickett, Jones, Hoffman, Flavell, & Scott, 2016, p. 13). Moreover, self-reflection extends to understanding the SDIPH and how social, political, historical factors impact Indigenous health outcomes and access to care (Delany et al., 2018). Ultimately however, understanding the contexts of Indigenous peoples’ lives can lead to prevention of stereotyping among health care providers (Allan & Smylie, 2015; Greenwood & de Leeuw, 2012).

Summary of Chapter 1

Chapter 1 began by introducing a *Social Determinants of Indigenous Peoples’ Health* framework to guide the literature review beginning with an overview of colonialism and racism. Following this, the chapter focused on the ways colonialism and racism manifest in health care to reproduce inequities in health and access to care for Indigenous peoples. The final section defines and discusses cultural safety as a strategy to address inequities perpetuated by the health care system by way of racism and discrimination.

CHAPTER 2: METHODOLOGY

A researcher's philosophical framework represents the knowledge systems and theoretical underpinnings of the research project in its entirety. According to Cree scholar, Kovach (2015), this is inclusive of the knowledge and experiences of the researcher as "the explicitness of our choices and the beliefs that influence them sends a purposeful message about who we are as researchers" (p. 42). Potts & Brown (2015) contend, that "we carry our framework, which is not inherently good or bad, around with us, and it is through this framework that we view the data" (p. 31). With this in mind, in chapter three, I discuss the frameworks that informed my research process, including methodologies, methods, and analysis. The nature of this research project gave rise to two contrasting, yet necessary approaches, Indigenous and western.

Indigenous Methodology

As Indigenous methodologies are an emerging field, I have drawn from the work of Kovach (2015, 2010, 2009). While there exists a number of components to Indigenous methodologies, I specifically highlight Indigenous epistemology and an objective towards decolonization as key features of my analysis.

Sahtúgot'ine Epistemology. My North Slavey name is "Doxhaé" which means "early spring time" in the English language. This name was given to me by étsi (grandmother). My English name is Karen. I am a Sahtúgot'ine (Bear Lake People) as my ancestral roots are from the Great Bear Lake area in the Sahtú region of the NWT. I am the daughter of Bésha Blondin and Edwin Hall. My grandparents on my mother's side are Eliza and Edward Blondin and my grandparents on my father's side are Hazel and Joe Hall. My mother is Sahtúgot'ine and Tlicho and was born and raised around Great Bear Lake. My father is a non-Indigenous settler born and

raised in Saskatchewan. My parents met after my father took a position as a renewable resource officer in the community of Déline, which sits on the shores of Great Bear Lake. I was born and raised in Yellowknife, and continue to live there with my husband Dave and my son Nahzé. In North Slavey, Nahzé means “Hunter”. I currently work for the Department of Health and Social Services as Senior Advisor, Indigenous Health and am working through a Master’s program.

This is how I have come to introduce myself in both my work and personal capacity since returning to the North in 2013. I tend to omit the part about my job title and education when presenting to Indigenous community members because in my experience I am far more credible and trustworthy because of my connection to the territory through my parents and grandparents, than my professional accomplishments. Following my introduction in these settings, I ask each participant to introduce themselves. There is no time limit or list of things to share; each individual shares what is important to them in that moment. Some people share very little, some share a lot, and some even cry. As an Indigenous person, I understand that relationships are built, and trust established, by sharing and opening our hearts to each other.

By introducing myself in this way, I hope to provide some insights into the values I have as a Sahtúgot’ine. Absolon & Willett (2005), as cited in Kovach (2010), state that “Indigenous knowledge systems are interpreted through personal story and self-location” (p. 54). Thus, I ground myself in the North Slavey Indigenous language. As languages are constructed based on a particular understanding of the world, Indigenous languages are rooted in Indigenous knowledge systems which are, in turn, foundational to Indigenous methodologies (Kovach, 2009).

Next, I talk about land and my connection to Deliné and the Sahtú region. I also introduce myself in relation to my parents and grandparents. Connections to family, ancestors, and place

are all integral to being a Sahtúgot'ine. Even though I do not reside in the Sahtú region, I feel a strong connection to that land. My grandparents lived a subsistence life in the Sahtú region and traveled by dog team, as did their parents before them. This also signifies the knowledge and expertise my grandparents, my mother, and other Indigenous peoples have gained from reading and living on the land since time immemorial. To exemplify the intrinsic relationship the Sahtúgot'ine have with the land, I share some written documents by my uncle who currently resides in the Déline,

We have lived, since time immemorial, in and around the shores of Great Bear Lake in what is now the Northwest Territories in Canada. We have always been, and still are, the original and only inhabitants in this place. We are an Aboriginal society which has always understood itself as a collective entity. We have a unique and intimate collective relationship with our lands and waters in and around Great Bear Lake. This is where we were placed by the Creator. This relationship defines who we are and where we are in the universe. (Blondin, n.d.)

The act of intentionally leaving my education and job title until the end of my introduction also privileges and centers my Indigenous identity and values – my connection to Indigenous knowledge, language, family and place.

According to Kovach (2010), grounding Indigenous methodologies in Indigenous knowledge that is specific to “tribal knowledge base” (p. 41) is critical. In a recent chapter I co-authored (Hall & Cusack, 2018), I discussed my personal journey as an Indigenous person and graduate student and how understanding how Indigenous methodologies are rooted in Indigenous epistemology was helpful. It also helped me to see that I am more connected with my Indigenous roots than I thought. Thus, when incorporating Indigenous methodologies in our research, a

natural place to start is with ourselves. As stated by Anishinaabe scholar McGregor (2018), research is akin to storytelling and that as researchers, we begin the story by identifying “the source(s) of our knowledge, not only those direct sources that contribute to a current project, but also those individuals and life experiences that along the way have shaped who we are” (p. 245).

In terms of my own research project, I state that, “my specific Dene epistemology, wrapped in my own personal and subjective experiences throughout my life, give meaning to my interest in examining how dominant health care ideologies perpetuate inequities for Indigenous peoples” (Hall & Cusack, 2018, p. 110). In other words, my values and understanding of the world (i.e. ontology), which shapes my epistemology, also shapes how I undertake research. Specifically, these values as well as a decolonized lens are embedded in the analysis of data.

Process Evaluation Methodology

As one of my research objectives was to assess the process of the cultural safety pilot intervention, a process evaluation methodology was selected to guide this element of the study. This section provides a brief overview of process evaluation, including the value of measuring process as well as its limitations.

While outcome evaluation has occupied a dominant space in evaluation approaches (Dehar, Casswell, & Duignan, 1993), process evaluation has built momentum since the mid-1980s (Linnan & Steckler, 2002). This trend can be attributed, in part, to the scope and nature of outcome evaluation. While outcome evaluation can reveal whether a program has been effective, it fails to identify the factors that are actually producing results (Linnan & Steckler, 2002). Saunders, Evans & Joshi (2005) state that “a program’s lack of success could be attributed to any number of program-related reasons, including poor program design, poor or incomplete program implementation, and/or failure to reach sufficient numbers of the target audience” (p. 134).

Process evaluation aims to fill this gap by capturing information during the implementation of a program to identify key features and conditions that have led to its outcomes (Linnan & Steckler, 2002; Dehar et al., 1993).

Process evaluation can be used for summative or formative purposes (Israel, 2002; Saunders et al., 2005). A summative approach is used to assess the extent to which an intervention has been implemented as planned (Israel, 2002). A formative approach uses process evaluation data to make improvements or adjustments to the intervention (Saunders et al., 2005). However, there is considerable diversity in the ways that evaluators define process evaluation and in what they measure in the process. Moore, Audrey, Barker, Bond, Bonell, Cooper, Hardeman, Moore, O’Cathain, Tinati, Wight, & Baird (2014) observe,

There is no such thing as a typical process evaluation, which the term applied to studies which range from a few simple quantitative items on satisfaction, to complex mixed-methods studies exploring issues such as the process of implementation, or contextual influences on implementation and outcomes. (p. 101)

Steckler & Linnan (2002) contend that considerable overlap and diversity exists in terms of process measures, thereby contributing to an overall “lack of a systemic approach to guiding process evaluation” (p. 9), which often leaves evaluators reinventing approaches and becoming overwhelmed. This is supported by Dehar et al. (1993), who conclude “authors in the evaluation field differ in the emphasis they place on different aspects of process evaluation, and the extent to which they specify the range of aspects that process evaluation should address” (p. 208). Other limitations include a lack of guidance around when to use quantitative versus qualitative methods for certain situations and studies (Steckler & Linnan, 2002).

While I am drawn to process evaluation given its focus on procedures and interactions,

these limitations led me to find a more complimentary model for my study. Based on the needs of the DHSS, I adopted a formative process evaluation approach, with a focus on the “dose received” measure, which refers to the extent participants interact, engage, react, and are receptive to an intervention and is synonymous with measuring participant satisfaction of a program (Saunders et al., 2005; Linnan & Steckler, 2002).

The Kirkpatrick model. As a systemic approach to process evaluation is lacking in the literature, I sought further direction from an existing training model called, the *Kirkpatrick Model* to assist with the research design of my study. The Kirkpatrick model is a successful international model of health services evaluation (Jones, Fraser, & Randall, 2018). I found this model appropriate and complementary to my process evaluation because (a) it focuses specifically on the evaluation of training programs and (b) “it can be applied before, during and after training to both maximise and demonstrate its value to the organization” (Jones et al., 2018, p. 494). The Kirkpatrick model seeks to “include measures of the processes behind the outcomes”, thereby making it possible to identify what aspects require adjustments (Cooley, Cumming, Holland, Burns, 2015, p. 107).

The Kirkpatrick model is comprised of four levels of evaluation. Each level is sequential, building upon the latter to inform the next (Kirkpatrick, 1998). See Table 3 for an overview of the Kirkpatrick Model Levels. As this study was concerned with how participants react and experience a pilot workshop, I employed the first level of the Kirkpatrick model, which focuses on reactions, to guide and expand on the satisfaction or “dose received” measure of process evaluation (See Table 4 to see relationship between process evaluation and Kirkpatrick Level 1: Reaction measure). Level 1 Reactions are “considered internal, because they focus on what occurs within the training program” (Praslova, 2010, p. 220). Both quantitative and qualitative

methods can be used to evaluate each level of the Kirkpatrick model (Jones et al., 2018; Cooley et al., 2014), which can produce “rich, explanatory, evaluation of both outcomes and processes (Cooley et al., 2014, p. 107). I employed a qualitative approach to understand how participants responded, perceived, and experienced the pilot intervention.

Table 3: Overview of Kirkpatrick Model Levels

Kirkpatrick Model Levels & Descriptions	
Level 1: Reaction	- Measures how participants react to a training program and learning environment post training - Also referred as “customer-satisfaction” - The theory behind this level is that positive reactions to programs motivates participants to learn
Level 2: Learning	Measures changes in learning as it applies to knowledge, skills, and attitudes
Level 3: Behaviours	- Measures changes in behaviours and transfer of skills and knowledge to workplace resulting from the intervention - Refers to the application of the new learnings in terms of knowledge and skills in the applicable environment - If no changes in behaviours are reported, levels 1 and 2 become critical to identify possible explanations (i.e. participant dissatisfaction or learning objective was not met)
Level 4: Results	- Measures the outcomes from increased learning and behavioural change as a result of the intervention - Described as most challenging level to measure

Adapted from McLean & Moss (2003) and Kirkpatrick (1998)

Table 4: Relationship between process evaluation and Kirkpatrick Level 1: Reaction measure

Process Evaluation	Kirkpatrick Model
Fidelity	Level 1: Reaction
Dose delivered	
Dose received	
Reach	
Recruitment	
Context	
	Level 2: Learning
	Level 3: Behaviours
	Level 4: Results

Methods

Interview Guide Development. Level 1 of the Kirkpatrick model guided the development of the interview guide (See Table 5), which was subsequently approved by my thesis co-supervisor. As a novice researcher, I found this guide helpful in the interview development process. In total, 8 questions were developed for the interview guide. A question pertaining to “feeling respected” was added following my co-supervisor’s suggestion. The final interview guide is included as Appendix B.

Table 5: Formation of Interview Guide

Kirkpatrick Evaluation Measures	Kirkpatrick Evaluation Questions (Kirkpatrick, 1998, p. 17)	Interview Questions
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Facilities	Are the facilities satisfactory?	Did the space of the workshop meet your needs?
Organization	Is the schedule appropriate for the participants? Was the coordination of the program satisfactory?	In what ways was the workshop well organized?
Content needs	To what extent does the subject content meet the needs of those attending?	In what ways was the content relevant to your profession? In what ways were the learning needs of your profession met during this workshop?
Teaching supports	Are the aids effective in improving communication and maintaining interest?	In what ways were the resources provided in the workshop useful? In what ways were the activities in the workshop useful?
Facilitator	Is the leader the best qualified to teach? Does the leader use the most effective methods for maintaining interest and teaching the desired attitudes, knowledge, and skills?	In what ways were the facilitators knowledgeable in the subject matter?
Improvements	What else can be done to improve the program?	Is there anything else you would like to say about the workshop?
Respect	* No Fitzpatrick question related to respect	In what ways were you made to feel respected during the workshop?

Participant Selection and Recruitment. Participants were recruited using a purposive sampling approach, which selects “those individuals or objects that will yield the most information about the topic under investigation” (Leedy & Ormrod, 2010, p. 147). This was an

appropriate method as participant selection was limited to those clinicians participating in the pilot workshop. The pilot workshop took place October 23-23, 2014 and included 15 physicians, nurses, and social workers who practice across the NWT, in Yellowknife and in smaller communities.

Special considerations were made as I was both a DHSS employee and researcher for the study involving DHSS participants. However, the DHSS is comprised of two branches, one ministry and the other operational. I work in the ministry branch and participants are employed in the operational branch. I was (and still am) currently employed in a DHSS division that focuses on health promotion efforts and not tertiary care. In other efforts to safeguard participants of any coercion or potential harm, a DHSS Administrative Assistant (AA), who was not part of the research team, played an integral role in the facilitation of my study. As an employee of DHSS, the AA had no direct power-over relationship with participants. The AA attended the intervention in a supportive role as the DHSS sponsor of the pilot workshop. AA responsibilities at the intervention included note taking and documenting the names of the participating clinicians. Contact information for DHSS and regional health authority staff is publicly available on the GNWT website under the phone directory.

Following the pilot intervention, and once my ethics approval was issued on February 16, 2015 and a Scientific Research License was granted by the Aurora Research Institute on February 19, 2015, on my behalf, the AA sent the approved recruitment email (See Appendix A) to those clinicians who had attended the pilot intervention. The recruitment email included my work contact information (email, work number and personal cell number) and the University of Victoria email. Interested participants contacted me directly, at which point, I provided detailed information about the study and screened for eligibility (See Appendix E).

Description of Participants. There were eight participants in the study. I did not collect demographics; however, participants were forthcoming about this information during their interviews. Three participants identified as nurses, with the remainder identifying as a social worker, psychologist, physician, and counselor; one participant did not report their profession. Only one participant identified as Indigenous. Seven of the eight participants identified as female.

As a means of balancing the epistemic tensions between the methodological approaches that I have employed, I opted to provide North Slavey pseudonyms to both participants and facilitators. The pseudonyms selected for participants are in honour of the relationships the Sahtúgot'ine have with the universe (i.e. moonlight, star, sky). The facilitators' pseudonyms reflect the many parts of a snowshoe. Snowshoes are an integral part of living for Indigenous peoples in the North as they equip one to traverse the snow for hunting, trapping, and living off the land. However, in order for snowshoes to function properly, the frame, netting, foot straps, and back crosspiece must all work together. I liken these pieces coming together as necessary for functioning snowshoes as the facilitators coming together for the delivery of the pilot cultural safety workshop. The pseudonyms for participants and facilitators are in the findings chapter.

Data Collection. In-depth interviews are a commonly used method for data collection in qualitative studies (Hesse-Biber & Leavy, 2011). In order to gain and understand the unique perspectives of clinicians who participated in the pilot workshop, this approach was appropriate. Researchers typically employ in-depth interviews to gain insights about a particular topic from select individuals who have knowledge in the researcher's area of interest (Hesse-Biber & Leavy, 2011). In-depth interviews can be highly structured, semi structured, or low-structured (Hesse-Biber & Leavy, 2011). A semi-structured approach was selected because I sought

flexibility to allow the conversation to flow organically while being guided by a set of questions (Hesse-Biber & Leavy, 2011; Leedy & Ormrod, 2010).

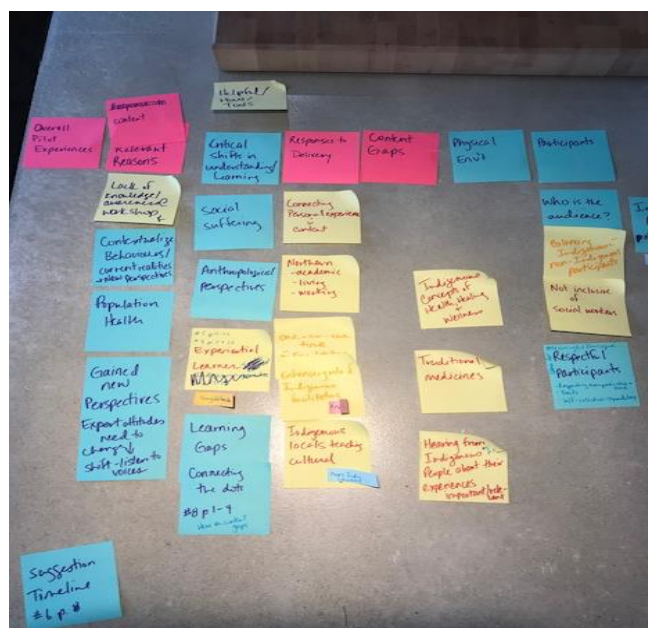
Between March 2015 and July 2015, I conducted eight one-on-one interviews with participants, which lasted approximately 1-2 hours each. Small sample sizes are acceptable in qualitative studies as the objective is to gain an in-depth understanding of a particular experience (Hesse-Biber & Leavy, 2011). I used a digital audio recorder to capture the interviews.

All of the interviews were conducted during work hours; however, participants were provided with the option of participating at other times. Given that half of the interviewees resided outside of Yellowknife, four interviews took place over the phone. The remaining four interviews were held in-person at each participant's office. According to Hesse-Biber & Leavy (2011), the quality of interviews decreases when conducted over the telephone as nuances, such as body language and eye contact, cannot be observed by the researcher. Although I did observe that participants were at ease and comfortable during the interviews, I did not detect a lack of engagement during telephone interviews. In fact, the longest interview took place over the telephone.

Data Management, Ethics, and Analysis. Following each interview, I transcribed the audio recordings verbatim. To familiarize myself with the data, I read over the transcripts several times. Following this, I listened to each audio interview and highlighted corresponding sections on the transcript that may be of importance and made notes.

The next stage involved coding excerpts from the transcripts. This process is also described as “open coding”, which aligns with a thematic approach (Gale, Heath, Cameron, Rashid, & Redwood, 2013). My process involved copying sentences and paragraphs from the

Figure 1: Thematic Analysis



Data Storage. All paper forms, such as consent forms and verbal consent log were stored in a locked filing cabinet in a storage facility only accessible by myself in Yellowknife, as per the University of Victoria's ethical protocols. All electronic data, including transcripts, have been kept on a password protected computer file on my personal computer. All data will be kept for five years following the completion of data analysis, where at that time, all paper forms of data will be securely shredded and electronic data will be permanently deleted.

Ethical Considerations. Several important ethical considerations are involved when conducting research with human subjects. The first step involved receiving ethical approval from the University of Victoria Human Research Ethics Board prior to conducting research with participants. A Certificate of Approval was issued on February 16, 2015 (See Appendix I). Secondly, as my study took place in the NWT, I obtained a Scientific Research License (research license) from the Aurora Research Institute. The research license was issued on February 19, 2015 (See Appendix J). The research license was also a prerequisite to data collection.

Informed Consent. Two methods of informed consent were obtained as interviews were conducted both in-person and over the telephone. Once interview dates were agreed upon, both in-person and telephone interview participants were emailed a copy of the Information Sheet and Consent Form for review (See Appendices C and G for telephone versions and Appendices D and F for in-person versions). At the beginning of each interview, I reviewed the consent form with the participant and assured them of their right to withdraw from the study at any point without repercussion to their employment. Once this was completed, I asked if they had any questions before asking them to sign the consent form. There were two copies of the consent form; I took the signed copy and the participant was provided with the second.

Privacy, Confidentiality, and Anonymity. Several factors were identified as limits to participant privacy, confidentiality, and anonymity. These included opting to participate in interviews during the work hours and that participants were drawn from a specific context of a pilot intervention. To mitigate any concerns, participants were offered the option to participate in the interview after work hours. Additionally, I did not use the names of the smaller remote communities in which some of the participants reside and I removed all names and potential identifying information from the transcripts prior to the analysis phase. My Master's thesis and summary report for the DHSS will be written in such a way that participants cannot be identified directly or indirectly. Further, the DHSS will not be made aware of who participated in the study and will only have access to the completed findings. These safeguards were communicated to participants prior to the interviews and signed consent.

Making Meaning through a Decolonizing Lens. Kovach (2009) emphasizes the need to embed a decolonizing lens within Indigenous methodologies. From an analytic perspective, decolonization has its roots in critical theory but is nonetheless considered an ally to Indigenous methodologies. In my analysis, a decolonizing lens is key. As an analytic lens, decolonization involves the analysis of power; particularly the ways in which Indigenous knowledge has been oppressed in past and current contexts. Decolonizing analysis makes space for, and the respect of Indigenous realities, viewed as valid and credible. This reminds us to account for the past and acknowledge how it informs the future; it encourages “colonizers [to] confront and be accountable for the traumas of colonization” (Denzin & Lincoln, 2008, p. 12). Decolonizing analysis also seeks to transform the “colonizer encounter” (p. 12) and actively pursues social justice (Denzin & Lincoln, 2008; Smith, 1999). Finally, a decolonizing analysis lends itself well to the work of cultural safety as it shares the goal of social justice and attends to structural

determinants (e.g., colonialism, racism) that continue to shape Indigenous health outcomes and access to health care.

Summary of Chapter 2

The Indigenous and process evaluation research principles that underlined this research project provided a framework for examining the perspectives and experiences of clinicians who participated in a cultural safety pilot intervention. This chapter also described the participant selection and recruitment; data collection; data analysis, reliability and validity; data management; and ethical considerations. The findings that emerged from this study will be presented in the next chapter, supported by participant quotes.

CHAPTER 3: FINDINGS

The purpose of this study was to examine the experiences of clinicians who participated in a pilot cultural safety training intervention and to make recommendations to the design, content, and delivery of the intervention. Four main research questions informed this study:

1. *How do clinicians experience or respond to the design, content and delivery of the pilot intervention?*
2. *What aspects of the pilot intervention were perceived by participants to be most relevant and applicable?*
3. *How do participants perceive or experience the overall pilot intervention of agenda, timing, activities, and content?*
4. *What improvements could be made to the pilot intervention to ensure an efficient, respectful, and engaging process?*

This findings chapter contains five sections based on thematic analysis as outlined in the previous chapter, which include responses to: (1) workshop content and delivery, (2) learning environment, (3) design and organization, as well as (4) overall feedback, and (5) contexts. Each section is comprised of sub-sections and is supported by key findings from the interviews.

Participants and facilitators were provided with North Slavey pseudonyms. See Table 6 for participant pseudonyms and Table 7 for facilitator pseudonyms.

Table 6: Participant pseudonyms

Participant Pseudonym (North Slavey language)	English Translation	Profession
Yát'a	Sky	Nurse
Bek'áhka	Morning star	Did not specify

Gorek'ale	Brightness	Social worker
Goba	Dawn	Psychologist
Adze k'əŋɪdɪ	Moonlight	Nurse
Sa	Sun	Counselor
Naətsɪ	Sunset colour	Physician

Table 7: Facilitator pseudonyms

Facilitator pseudonyms	English Translation	Facilitator
ʔahtɪ'ákw'a	Back crosspiece	Indigenous Northern Knowledge Holder (female)
ʔah ɪʔálé	Foot straps	Indigenous Northern Knowledge Holder (male)
ʔahkw'ené	Frame	Indigenous physician (female)
ʔah hehga	Netting	Non-Indigenous consultant

Workshop Content and Delivery

Participants' responses to workshop content & delivery represent the most comprehensive findings. This section is organized by individual workshop sessions, with the exception of sessions one and two that have been collapsed. Because the data correspond directly with the individual sessions and specific learning objectives, tables have been provided as a reference guide for sessions one through four. The five sub-sections are arranged in the order in

which they occurred in the agenda: opening session; sessions one & two; session three; and session four.

Response to Opening Session (Smudging and Fire Feeding Ceremony)

Participants were particularly moved with the opening session at the beginning of day one that consisted of a smudge and fire feeding ceremony. Not only did participants feel respected by participating in the ceremony but they also described the effects as calming, which in turn, set a positive tone for the rest of the workshop:

I always enjoy experiential activities, so I enjoyed the, you know, the opening with smudging and feeding the fire and for me, that really grounds me in an experience. (Sa)

Interviewer: *In what ways were you made to feel respected during the workshop?*

Well I think the workshop was overall very respectful; it started with ceremony, which again for me, is pivotal so this was a cultural think tank and it started with ʔahtl'ákw'a and ceremony and I think that was so appropriate, so I think that was all respectful for the Aboriginal culture that we were there to work with but also for ourselves, I felt respected in that moment. I mean when ʔahtl'ákw'a sang that song, that was so beautiful and healing. You know you could just feel, you could just sense that. Yeah, I think non-Aboriginal people are very concrete and black and white and, let's do this and let's have outcomes and measure this" and, you know, so I felt to just slow everything down and follow ceremony was tremendously respectful for everyone there. (Goba)

So, the opening ceremonies were very, like for me, centering? I don't know how to really describe it, but it was a really neat way to, for me, to kind of get rid of all the busy-ness in my brain and focus on where I was. (Bek'áhka)

...with ʔahtl'ákw'a leading the opening ceremonies and explaining the opening ceremonies in the teepee, I think was just a fantastic start to it. To not just going and starting off with a prayer but starting with a prayer with the passing of the pine boughs and the, I can't remember if it was pine boughs or something that was passed around, and the significance of it and what it meant, I think just set the stage and the tone for the rest of the day. (Naətsł)

Session One
Context: History, Policy, Law and Social Suffering
Delivered by: ʔah hehga

Learning Objectives	Response to Content	Response to Facilitators
1. Indigenous peoples in the NWT; traditional territories and political agreements.		Qualities • Preference for Northern facilitators Teaching methods
2. Major policies, legal structures, events and social phenomena impacting Indigenous peoples in the NWT over the past 50 years.		• Sharing vulnerabilities
3. Colonization, historical trauma, social suffering, settler colonialism, Indigenous resurgence and cultural safety and importance of these for the lived experience of Indigenous peoples.	• Perspective shift • Avoidance	
4. Social determinants of Indigenous peoples' health.		
5. Overall feedback	• Lack of knowledge	

	• Improved understanding of Indigenous patients and clients • Professional and social responsibility	
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Session Two Local Experiences Delivered by: ʔah hehga, ʔahtl'ákw'a & ʔah ɪʔálé		
Learning Objectives	Response to Content	Response to Facilitators
1. Land use pattern and knowledge of Yellowknife area.		
2. Impacts of Yellowknife Giant Gold Mine on Yellowknives Dene land use, health, and ability to engage in social and cultural norms.		
3. Port Radium uranium mines by ʔahtl'ákw'a		
4. Community experiences and residential schools by		

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5. Overall feedback		

Response to Content: Overall Feedback

Sessions one and two have been merged in response to participants providing general feedback about colonization and the fact that both sessions contain information about colonization (session one focused on broader colonial and assimilation policies in Canada and session two highlighted NWT specific examples of colonization).

Lack of knowledge. Participants provided various explanations about the significance of the content delivered by ᓃᐱᐱ ᓃᓃᓃᓃ on Indigenous history and colonization. Several participants recognized gaps in their own knowledge about colonization, which prompted them to reflect on their clinical practices with Indigenous patients and clients:

Interviewer: *In what ways were the learning needs of your profession met during this workshop?*

... probably the background to some of the etiology and the history of the Indigenous people in the Northwest Territories. I've practiced clinically in the Northwest Territories for twenty-four years and lived in Canada all of my life and I've never actually known some of the Canadian history. To me, just that knowledge of where people were coming from or where they were grounded gave me a different perspective on how some of the issues and relationship. Things that we [clinicians] deal with on an inter, day-to-day clinical interaction; that they [interactions] may actually have a role. (Naətsi)

Interviewer: *In what ways was the content relevant to your profession?*

... A lot of our clients identify with that [First Nations] background. I feel understanding better some of the history and what that looks like helped me, kind of open my eyes a little bit, to the implications of my interactions with individuals and I guess how we do things as an organization. (Bek'əhka)

Participants also focused on the lack of knowledge and awareness among other participants at the workshop and clinicians in general:

Interviewer: *In what ways was the content relevant to your profession?*

I can't stress the, how much the content, it was very relevant. Just on the knowledge, as I say that the amount of jaw-dropping that I saw there, were these, everybody at that session was an educated professional in the Canadian health care system, and of the fifteen or so people that were there, I don't think anybody would really say that they had a knowledge that this happened in Canada. (Naətsj)

One thing that is becoming very clear to me is that a lot of health professionals know very little about the history of Aboriginal people in Canada, and even less in the North. (Adze k'əṇɪdɪ)

Improved understanding of Indigenous patients and clients. For some clinicians, learning about Indigenous history helped them to contextualize and better understand their Indigenous patients and clients:

Interviewer: *In what ways was the content relevant to your profession?*

... I think everybody needs to know it [the content] ... anybody working up here needs to know that history and the context of what they're walking into, right? They're [clinicians] gonna get reactions from people and not understand them if they're from the South... (Sa)

For example, understanding key historical events, such as the forcible removal of Indigenous children from communities for TB treatment, is essential in order to understand prevailing fears of being removed from communities and never returning:

You know, because people maybe don't know when the last residential school was started or when was the TB outbreak... you know things that took people out of their communities. Because there are people that left here for TB treatment that never came back. Now we hear that some of those children were adopted out, many died, were never returned to their community. Families never knew what happened to their loved ones, right? And I know, as a clinician talking to some of those Elders as they were passing on, there's still a hole in their heart from not being able, not knowing what happened to their child when they're sent away for TB... So, those kinds of events, I think are really important because sometimes when Elders are dying, they don't want to leave the community because they're afraid they won't be returned. (Adze k'əṇɪdɪ)

Professional and social responsibility. Participants directly connected learning about Indigenous history to the context of professional responsibilities and healing. Several participants

stressed that clinicians are in the business of healing; therefore, information about Indigenous history and colonization is relevant, given their clients are predominantly Indigenous:

Interviewer: *In what ways was the content relevant to your profession?*

You know hearing stuff, when you speak about the impacts of colonization... the work that we do in child welfare in the North, almost all of our clients are First Nations/ Inuit people and they're suffering because of everything we discussed in those two days. You know, this is the work that we're doing - is healing these impacts. So, you know for me, it was all relevant; my work is to take that information and translate it into - when you're doing these duties as a social worker, how do you try not to perpetuate the harm? How do you try and heal the harm. (Gorek'ale)

And so, for my profession [counselor] you need to kind of know it all, right? If you're gonna work that directly with the people and trying to help them heal that pain we need to know it all. So yeah, I can't think of anything that would be less relevant or more relevant. (Sa)

Adze k'ənıdı describes understanding Indigenous history as a social responsibility and a necessary step to repair the relationship between Indigenous and non-Indigenous peoples.

The damage is done and I think everybody has to understand their role in what has happened, whether you're Aboriginal or non-Aboriginal and what you can do. Everybody has to do their part to, to fix that and to heal. But we all have to understand where we've come from. (Adze k'ənıdı)

Education was viewed as essential to improving Indigenous health and wellness outcomes:

So, I think it's very relevant to their [Indigenous peoples] health and healing and wellness, and to educate health professionals. I think [it] is really key to changing health statuses of people in the North. (Adze k'ənıdı)

Response to Content: Impacts of Social Suffering and Settler Colonialism

Perspective shift. The learning objective related to the impacts of social suffering and settler colonialism was helpful to several participants, who described how these concepts facilitated critical shifts in their perspectives about issues they encounter:

In what ways were the learning needs of your profession met during this workshop?

...One of the things that I really appreciated hearing about was the suffering, the social suffering in the context as was presented. I think that's really important to know because it encourages one to really step outside to be able to look back into the, you know, area of being or practice of, or give them another perspective of seeing things, and I, I found that was really helpful. (Yát'a)

We aren't living in a post-colonial society you know. In, in fact, you know the people are colonized and that's, you know when, when people are saying things like "why don't they just get over it", right? Well, it's, it's not get over-able when it's still happening. And so, that sort of anthropological perspective, I found quite, quite useful. (Sa)

Colonial perspective. Another participant seemingly attempted to subvert the discussion about privilege by turning attention away from settler colonialism and seeking to discuss ways to move forward as a united society. In his response, his own colonial perspective emerged as he appears unconvinced that settler colonialism is relevant to him or mainstream society. While this participant did not outwardly indicate these opinions were his own, the level of detail in his response indicated otherwise:

Interviewer: *In what ways were you not made to feel respected during this workshop?*

There may have been more room... about some of the discussions from some of the presenters were that, particularly from the, as classic as you can get hundreds of generation white Caucasian settler descendant about how is this my problem at this stage... it's one of those underlying ones, where I don't think everybody is into the context of looking at this as a settler society or a settler country. I'm not sure if that's the right word, and our presenters are coming across that this is didactically the way it should be when I'm not sure there's agreement on that. We all recognize that yes, that there is a problem and how we got here, there's no, I guess there's some debate about the history even which wasn't known, but still to say that that makes us a settler state or whatever the terminology is, is one of those ones where the terminology itself is, I think we need some further clarification because there's a lot of discord about that... we are here at the present and have to move together as a team or as a society, a unified society, that... slicing and dicing into various stratifications of society is not going to be the way forward... (Naətsi)

Response to Facilitators

For many participants, it was not enough that facilitators were knowledgeable about a specific area. Knowledge and credibility also result from years of experience working and living

in the North. Although participants found ʔah ʔálé knowledgeable, they demonstrated a very strong sense of connection and preference for Northern facilitators over those from the South:

So, for ʔah hehga, there seems to be a very significant background living and working in the North, a real true sense of dedication to it. (Bek'áahka)

ʔahkw'ené has a lot of good ideas... she does some good work and she's got a good reputation, but I would think that, myself, I would use somebody like [name of a local Indigenous clinician]. Or myself, you know, we have practiced in the North for years, right? And I think it should be Northern. (Adze k'énıdı)

I think Northerners [as facilitators] could tell their story really well. (Yát'a)

... ʔah hehga has a lot of knowledge. I think from her academic research, also from her experience living and working in the North. And I think that a lot of her academic research has been really unique and kind of groundbreaking, and especially in her way, that she's been able to apply it to what's happening in the North. You know and really use that to draw the parallels, I guess between cause and effect. (Gorek'ale)

One participant found it helpful when ʔah hehga shared a vulnerable story about her work in the North. These stories may resonate with new clinicians from the South who possess “saviour complex” tendencies:

I appreciated her [ʔah hehga] story about how she came to that curiosity and, you know, she had worked a lot with the local [Indigenous] people and wanted to be helpful and then found out they didn't really want her all the time! And so, she went off to be curious about that! And I think that the Southerners coming up here could relate to that, right! And, and so I think not only the fact that she's the direct person but, you know she did have that and other personal stories that helped you make the links. (Sa)

Session Three Indigenous Experiences of Colonization Impacts Delivered by: ʔahıł'ákw'a & ʔah ʔálé		
Learning Objectives	Response to Content	Response to Facilitators
Content Presented		
1. Personal experiences as		• Story-telling

healer drawing on cultural and land-based healing; personal and family impacts of residential school; cultural and social connectedness and relationship as a source of resiliency (Delivered by ʔahtl'ákw'a).		• One-on-one time with facilitators
2. Profound shift from being raised on the land; the pressures faced by those impacted by residential school experiences and the struggle to overcome the personal responses to that trauma; the importance of the land for healing (Delivered by ʔah ɪʔálé).		
3. Overall Feedback	• Northern Indigenous facilitators • Inadequate time for traditional medicines • Clarification	

	• Lack of knowledge • Empathy • Blame	
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Response to Content: Overall Feedback

Northern Indigenous facilitators. Hearing directly from Indigenous facilitators about their personal experiences and stories, particularly related to residential schools, was extremely valuable for participants' learning and content needs:

...I was very impressed with the experiences of ʔah ʔálé and ʔahtl'ákw'a; about their experiences and how they were able to bring that into the workshop. I thought it made it very rich. (Adze k'ə́ndi)

... There were the experiences sharing about residential school and the experiences of the people themselves. I think there was value to that...the sharing of the experiences of the people to hear about. (Yát'a)

... Listening to the stories I think is pivotal. As a, you know, as, as an individual that is working amongst Northern Aboriginal populations, right? (Goba)

One participant appreciated having gendered perspectives:

I think it really made a difference to have a male perspective of lived experience and a female perspective of lived experience and I think that's really good to have. (Yát'a)

Inadequate time for traditional medicines. Although noted by many participants as important, some felt that the component about traditional medicines lacked adequate time on the agenda:

She [ʔahtl'ákw'a] had some very interesting traditional medicine that she wanted to show, and it was kind of unfortunate that kind of got rushed at the end because we didn't have time. And, and it was very interesting to learn what she had and what's it used for. (Whé)

And like, I liked to see the medicines there, cause I'm just very visual and I liked to kind of... and I wish we had more time to do that. (Adze k'ə́ndi)

Participants provided several reasons why learning about traditional medicines is

important for clinicians. In the context of cultural continuity, one participant explained that learning about the resilience and strengths of Indigenous peoples, such as maintaining cultures and traditional knowledge, is just as important as content about colonial trauma:

... we want to be sensitive and that's what the workshop was teaching us about – the context and the pain. But I want to know about the resiliency and the strengths... there's people that have their problems but the culture is strong... You know, out of respect for that, like what is it that's inside the people that's enabled them to, to maintain their strengths, to maintain their dignity in the face of all of this colonization and crap. Holding onto the traditional knowledge like traditional medicines would be one of those things. (Sa)

This participant later added that focusing on Indigenous strengths is necessary to avoid portraying Indigenous peoples solely as victims:

Just because we, you know we also don't want people going out to work in the cultural - with the idea that everybody is just a victim. And they're not, they're, they're survivors and thrivers. ʔahtl'ákw'a and ʔah ɬálé both show that. (Sa)

Broadening clinician knowledge and acceptance of healing modalities beyond western medicine, including understanding Indigenous concepts of healing and wellness, is vital to Indigenous peoples' wellness and to an individual's healing journey:

I think just that education that, "you know what docs? You're only one part of this system. And all of this other stuff is still going on, whether it's endorsed by you... or not, and these are some of the people who provide it and these are the benefits that people feel that they get from it". (Naətsɪ)

So, but when you work with Aboriginal people, spiritual connections are very, they're there. You know? And people are still connected to land, and when you say, you know, go back to, to the bush and, you know, pray and, and ask Creator for answers, [Indigenous] people understand that. You know? But western clinicians don't understand that, they don't, it's kind of not really there, and when you open up that conversation, I think it makes a big difference in how people heal. So, if they, I think if there's better understanding of that, then I think it's gonna to make a big difference in healing. (Adze k'əɲɪdɪ)

Clarification. One participant reported that learning from the Indigenous facilitators, about their residential school experiences, helped to clarify prior misconceptions based on

limited knowledge:

Interviewer: *In what ways was the content relevant to your profession?*

Yeah, like I say, a lot of this is information - I just never had and it's nice to know, you know, you hear... about residential schools and the impact and then the only person I know personally that was in a residential school says, "hey that was the best thing that ever happened to me", you know, "the settlement was great, you know I went through a period of confusion in my life but" he said "so did most, most of my friends did too, you know, I don't know that that was that but you know, got myself together and this was like, this was my retirement bonus". So, it was always kind of a controversy in my mind because the only person I knew who went, who had experiences in residential school had a very positive one. He felt that it was a very good thing. This gave me some insight into the destruction of family that residential schools had, and I had no idea about that. (Whé)

Lack of knowledge. Related to participants highlighting gaps in the knowledge of fellow participants, a similar observation was made about residential school experiences specifically:

I'm always kind of surprised when this is new information for people because it hasn't been new information like, in terms of residential school experience and First Nations peoples' experience... I'm always surprised that they are new for some people... But like even, like sitting at the table there, I was surprised when we did go around at the number of people who said, "oh, I've never heard this before, I can't believe I've never heard this before!". And I was like, yeah, I can't believe it either. (Sa)

Empathy. Hearing about residential school experiences elicited emotional responses directed towards the Indigenous facilitators and residential school survivors in general. The following participant expressed empathy over discomfort:

Honestly, I did not feel discomfort because the stories that were shared... No, I, I did not feel uncomfortable or any of the discomfort as such. Because, you know it's more empathizing with what I heard. (Yát'a)

Despite not feeling discomfort herself, Yát'a states that discomfort is an opportunity to engage in meaningful discussions:

The other thing too is that, I think, when you start to stir the pot and you start to create a discomfort in the room it's an opportunity for possibilities. So, you know, talking about the experiences of the people, the residential school experiences, the living experiences of

people, it makes people feel dis-comfortable. And it's a time for conversation. And I think that depth and breadth of the conversation will come. (Yát'a)

Another participant called the Indigenous facilitators courageous for sharing their difficult experiences for the purpose of educating others:

Yeah, and then, you know I always appreciate the bravery of people who are willing to step forward and, and speak about, you know heart-rending experiences in order, especially in order to help people, other people understand. You know I don't know if it may or may not be of benefit to them but they're doing it for others and it's got to be painful every time. And, so I'm, so, you know I always feel honoured by that, by people being willing to, yeah speak of those experiences. (Sa)

Blame. When confronted with her own deficits in awareness about residential school experiences, one participant placed blame on Indigenous peoples for not sharing those experiences:

... it's one of those things that everybody talks about it but unless you're part of the circle nobody talks about it... and you know you're curious but when you ask, "well we don't want to talk about it" [Indigenous responses] ... I've always felt there's this expectation that I would know and understand but nobody [Indigenous people] wants to share it... And this was the first time that I felt that there was any talk about it and sharing [residential school experiences]. If you want my buy-in...you need to share your information and that was what I felt happened, is there was sharing of information and explaining. Because if you haven't been through it, you don't know. (Whé)

Response to Facilitators

Story-telling. Participants valued the story-telling approach used by the Indigenous facilitators. One participant described the story-telling as "foundational" to her learning:

So, I really appreciated their, them sharing and using the Aboriginal story-telling approach and for me that, for my learning, that was more foundational. (Goba)

For another participant, Indigenous story-telling challenged conventional methods of learning by having participants simply listen and connect to the content in a different way:

...when you do circle learning... you're not going to write down everything and say, "zah ɪzálé said this and zah ɪzálé said that". If you connect with zah ɪzálé's story, you're going to remember zah ɪzálé's story... you have to make that really clear, that it's not always about writing everything down and remembering verbatim...we're [Indigenous

peoples] taught through storytelling, we discipline our kids through storytelling... stories are timely and meant to be that way so that you learn. (Adze k'əndı)

The significance of story-telling was echoed by another participant who wondered how the training might have differed if the Indigenous facilitators were responsible for its design:

It's just my opinion but I find that often Aboriginal teachers will move into a story and then, and share it, and be done when there's a wealth of knowledge and wisdom there. So, I'm just kind of curious if we handed them a blank agenda, what would they have put on it? (Goba)

One-on-one with facilitators. One of the suggestions emerging from the interviews was to incorporate opportunities for participants to meet individually with Indigenous facilitators for mentorship and advice:

So, and maybe individual one-on-one; I know when I've gone to health leadership conferences, you can meet one-on-one with a health leader for example, a CEO, and get some mentoring feedback so, you know. Yeah, so if we did something like that at it, we took a half an hour... I would have loved a few minutes, you know with ʔahtl'ákw'a or ʔah ɬálé to just chat and say, "you know here's kind of where I'm struggling with cultural aspects" or, "you know do you have any feedback for me?", so. (Goba)

Session Four Building Culturally Secure Clinical Practice Facilitated By: ʔahkw'éné		
Learning Objectives	Response to Content	Response to Facilitator
1. Successful Indigenous health models and approaches		- Identifying biases - Concrete examples
2. Understanding and acknowledging the issue: a) Differences in quality health care access	- Ignorance - Discrimination in workplace	

(research) b) Definitions:discrimination, racism, systemic racism and discrimination (implicit/explicit, intentional/ unintentional) c) Implications of stereotyping and discrimination	• Racism can lead to disengagement	
3. knowledge building and skills for clinical practice: a) Cultural safety b) Critical thinking and reflexivity c) Linking individual action to system wide change	• Feedback wanted • Concept confusion • Self-Reflection and professional backgrounds • Racism and white privilege	
4. Overall Feedback		

Response to Content: Acknowledging and Understanding the Problem

Ignorance. Perhaps as an example of how difficult it can be for some people to acknowledge personal biases and discrimination, the following participant does not seem aware that she, like everyone, possesses biases and likely acts upon them:

I spent thirty-some years of my thirty-five years working in the North. Like I say, it would have been really nice to have this earlier and you know, you kind of get your coping

mechanisms. Mine has always been that, you know, you treat people as people. It doesn't matter what they've done, they're still a human being that needs some help. (Whé)

Discrimination in workplace. Among participants, there was a strong sense that racist attitudes and discriminatory behaviours are pervasive in the workplace and that clinicians are largely unaware of this issue:

... there's some wonderful people that come through and there's some other people [staff] that I, I'm really not sure I fully understand like, when hearing the ways they give a report about certain people; it, it makes me wonder why they're there. (Bek'áhka)

Because you can't generalize people, right? You can't. And I think that's what's being done sometimes, it's, it's generalized and you know... (Yát'a)

We have to get more clinician engagement or acknowledgement that this is a problem here... we somehow have to get physicians to realize that this is not somebody else's problem. That this is not clinicians elsewhere's problem. (Naətsí)

Response to Content: Building Knowledge and Skills for Clinical Practice

Feedback wanted. One participant appreciated the ability to seek feedback from the facilitators with academic training about ways to avoid discriminatory practices:

I think I'll just add it was also helpful from more of a clinical practical place that I'm coming from to kind of run my ideas by the more academic people that were there to say, these are my approaches about how to possibly you know navigate some of these areas like, do you think that would be helpful or not in getting that feedback cause we don't have a lot of like resources or consultation to do that. So that was kind of a cool aspect where I was like, "maybe I'm just perpetuating harm but if I am let me know!" (Gorek'ale)

Concept confusion. Participants' responses varied in terms of understanding the purpose of the workshop, including the term cultural safety. Participants' learning expectations were more focused on culturally sensitive approaches that focus primarily on cultural teachings by Indigenous peoples:

Interviewer: *Can you think of anything that needs improvement?*

Well, we didn't know what, what was going to be there going into it, so you know, we were told it was a cultural-capabilities think tank, what does that mean? We knew they were bringing people in from various regions and, so what I assumed there would be

Aboriginal people there as well; so I was really, really happy that they were there to teach us. (Goba)

It was a three-day thing. I remember when I was hired, it was down at NUP [a Yellowknife building] but it was very free-flowing and I was the only non-Filipino that was on the course and I learned all kinds of things about the culture of Philippines but not much about, what I was looking for was more culture around Inuit because I'd never worked with Inuit... You know, so many things, its learning idiosyncrasies and learning to respect other cultures. (Whé)

Self-reflection and professional backgrounds. Participants from different professional backgrounds understood and engaged with self-reflection or reflexivity. Several participants demonstrated a thorough understanding of self-reflection resulting from their respective training:

As a psychologist, I know that's not true, we all do [have biases]. It's about how we manage them, it's impossible for us not to have them you know, but being aware of them, working on them, managing them is the answer. And yeah, uncovering them... if they're glossed over, they're going to come out and they're going to come out in the way that you treat people. And how you interact with individuals... (Goba)

And I know like, from social work school where it was like, you know, they told us at the beginning, you're going to deconstruct your, basically your values and beliefs and reconstruct, and it's an intense process but we also had two years. (Gorek'ale)

Others, such as Naətsí, who self-identified as a physician, had more understanding how this relates to patient and client care. Although he demonstrated concrete and cause-effect thinking, he also demonstrated elements of self-reflection, a key skill for practicing cultural safety:

The course itself, I think, was great on a basic foundational building and I think that's the intent of the course, is to build that foundation. However, to get to the actual practicalities of the in-the-office and physician-to-patient or clinician-to-patient or clinician-to-client interaction, there's a lot more skills that have to be learned, which are very, very, sometimes very, very broad in knowing yourself and that your effect on others and particularly your effect on others from a different culture and how that inter-relationship is playing out. The, so to move from that broad foundational piece to the practical piece in the clinic, I don't know if it's a linear progression or if it's a relationship, and that's one of the things that I struggle with. Just the fact of having that knowledge, has that improved my relationship? (Naətsí)

Racism and white privilege. According to the following participants, feelings of denial, guilt and blame are normal responses when individuals are put in situations where they have to face their own biases and privilege. These experiences can have several implications in terms of engagement:

I myself am a white person and if, admitting that I have, like tendencies for prejudice to someone who is a minority, is additionally hard. Like it's, it's tricky to maybe talk about that frankly with, like I don't know, someone who doesn't face those same discriminations in daily life. But then when you are having a day that's focusing around being more mindful and looking at the impact of the things that have happened, then it can create a situation where you really want to shut down and hope that no one notices that you may have some minor concerns in your own day-to-day life that may affect the people you interact with. (Bek'áhka)

So, I think part of that process is often resistance from participants, right? To acknowledge their own privilege and you know racism, that they've been carrying around and then guilt, that's all part of the normal process... (Gorek'ale)

Response to Facilitator

Identifying biases. For some participants, entering discussions that are uncomfortable means knowing that others have struggled as well. Despite the challenging subject, ʔahkw'ené's non-threatening and honest approach about her own biases was helpful for several participants:

... she has lovely manners, so I think she was able to provide that information and not be threatening. I think that's really important because, you know people obviously, they go into these professions because they like to help and they care and they don't want to think that they have any kind of biases or racism...and of course she lead with herself in talking about you know, some of her own kind of uncovering some of those herself, which was beautiful right? So that, like we don't have to be afraid to admit that sometimes, you know we have... some of these biases or whatever, but we can uncover them and work on them still. (Goba)

I think actually, part of what helped me feel at ease sharing different thoughts was I think actually, when ʔahkw'ené identified some of her own biases... (Bek'áhka)

Concrete examples. Participants highlighted specific ways that ʔahkw'ené assisted their learning. For example, the following participant appreciated that ʔahkw'ené provided examples of racism in health care as a means of concretely demonstrating both culturally safe and unsafe

care:

... she [ʔahkw'éné] had really good concrete examples of her research into how racism actually plays out in service delivery... So, for me, that was really good learning about things I could take away and use in my training to talk, you know. I find, when I'm doing front line training, we talk vaguely around being culturally competent and it's more helpful to give examples about, you know, ways to do that and concrete ways where we fail to do that. So that was helpful. (Gorek'ale)

Learning Environments

This sub-theme represents the different environments identified by participants as most relevant in terms of their learning and emotional needs. The following three dimensions will be discussed:

- 1) Away from City and on the Land
- 2) Creating a Safe Space for Dialogue
- 3) Experiential Learning

Away from City and on the Land

Participants were overwhelmingly positive about the setting and location of the workshop. Comments such as, “*the space was welcoming and grounding*” (Sa) and “[the setting was] *better than an office or boardroom*” (Adze k'əŋɪɖi) were expressed during the interviews.

Above all, participants appreciated being away from the city and on the land:

I think the, the structure of the, the location, the venue itself, I think there's a lot to be said to getting people away from the everyday office, and even out of the city building for something like this, back to the nature and closer to land. Not that - it wasn't really on the land; it was a beautiful building and stuff, but just the fact that it is out there, that you could walk outside into a beautiful setting... (Naətsɪ)

The remoteness of the venue meant that participants could fully engage without being distracted:

The nice thing about being away is you've less disturbances. If you have anything in Stanton [Yellowknife hospital], I have this innate urge to run and do something during my coffee break, my lunch, or get something done and then I don't get back on time, you

In response to the interview question, “*In what ways were you made to feel respected during the workshop?*” many participants identified the importance of respectful environments in which to learn, engage, and discuss critically about cultural safety. Not surprisingly, participants may feel more at ease participating in challenging discussions if they do not feel judged by facilitators and other participants:

Yeah, I generally felt respected the entire time. I had my own individual discomfort just realizing the depth of the impact from colonization, all those peoples’ personal stories and impact of racism - so those were things that had me reflecting and feeling uncomfortable but at no point did I feel disrespected. And in fact, I felt very much invited to the discussion in a non-judgmental sort of approach. (Bek’áhka)

Some participants associated feeling respected with their ability to participate and share in discussions during the training:

... another way that I felt respected was when, I guess each person had a chance to share their own thoughts. Each person had time that was valued, that they wanted to hear feedback. So that was really helpful as well. Of course, knowing that you didn’t have to say something but if you needed to, that opportunity was offered naturally. (Bek’áhka)

I think everybody was on the same playing field, I think everybody was listened to and heard and I think it really was about, you know, listening to the experiences of other people and knowledge that was being shared... (Yát’a)

Factors affecting safe spaces.

Balancing Indigenous & non-Indigenous participants. Adze k’ən̓ıd̓ı identified ensuring adequate Indigenous representation at cultural safety trainings as an important consideration. She expressed how the lack of Indigenous participants at the workshop confused her. This could be the result of the intervention being labelled as both a “think tank” and “cultural safety training”:

Interviewer: *And you had identified yourself as an Indigenous clinician, so as an Indigenous clinician, so you, you felt respected too in the context of the, what you were learning and the people around you?*

Yes. And I really felt, like when I first came into the room and I thought, wow there’s no Aboriginal people here, how could you have a cultural think tank without Aboriginal people? Like I don’t get that. And I noticed the majority of people were non-Aboriginal,

and I don't know how many other clinicians there were. Aboriginal, I don't know. And it would have been nice to have more of a balance. (Adze k'əŋɪdɪ)

She further explained that Indigenous participants create a supportive environment for each other that, in turn, results in better participation:

I didn't feel disrespected but always, when I look at the agenda and the participants, I think having a balance of Aboriginal and non-Aboriginal people is really important. Because I think we learn from each other and if only one or two people show up that are Aboriginal and ninety percent of the room is not Aboriginal, a lot of times you're not gonna say anything. You're not... gonna correct anybody... when people stand up and say, "oh... you guys just need to get over this... people just need to get over it". And it's hard to respond to that when you're the one Aboriginal person there... So, I think that it kind of balances things out and... you have better participation. (Adze k'əŋɪdɪ)

Social worker representation. Gorek'ale described that being the only social worker engaging in the workshop was challenging, particularly since the workshop was geared more toward the medical field:

I felt like I was, you know, the only person really speaking to some of our unique services that we deliver. You know, a lot of people were talking about issues with signage in clinics and you know, we go right into people's homes and I, so I felt like I was kind of the only person at the table that was in that boat. (Gorek'ale)

Voluntary participation. Several participants identified a possible link between volunteering to participate in the workshop and the respectful environment they experienced:

And I'm just really impressed with how accepting all of the people were that were at that cultural think-tank [training]... I don't know if it was just that they were chosen or whether they were just saying, "I'm interested in this, maybe you can help me?" I noticed a lot of them were long-term, a lot of them had worked in the Territories for a long time. (Adze k'əŋɪdɪ)

I felt respected. I think it was a, a feeling of mutual respect there. The participants that were there had self-selected themselves as wanting to move along and learn more about this area, which I think created a good environment to start with, and then the fact that everybody was open and would listen to opinions whether or not they may disagree with it or not disagree with it, nobody was mean. (Naətsɪ)

Later, Adze k'əɲɪdɪ cautioned against mandatory training, as there is potential for backlash and disruption from those forced to participate. Instead, training should focus on staff that are ready for change:

I think offering training when people are ready for it... I've gone to workshops where people have been forced to go there cause they're so-called incompetent... So, you're gonna make them go to this workshop and they just are... They just kind of bring everybody else down or, you know they're just defiant to the, the facilitators and, and stuff like that... you know just start with those that are ready. Take the path of least resistance 'cause you'll burn yourself out if you try and convert people that are not ready. You know, and it's the same as working with somebody who is a hardcore alcoholic who's on a, coming off a drinking binge. You're not gonna change them at that point cause they're not ready. You know, when they're ready and they've had some kind of awakening then yeah, have services ready and available for them. (Adze k'əɲɪdɪ)

The following comment may further demonstrate a connection between participants already invested in cultural safety and positive learning experiences at the workshop:

For me, it was wonderful to get together with other people who also agree that it is so important in their work and to hear them and their comments. (Goba)

Experiential Learning

Responses in this sub-category indicate that many participants appreciate experiential learning approaches:

I'm not a learner that just learns by reading... I'm both experiential and very practical... (Sa)

I've been to workshops where you're not even allowed to have a pen, you need to just listen... So that's what I would do, I mean I would do a section where, you know the morning is just listening or the afternoon is just listening and you can go home and reflect on this and then take, take what you can from it, right? (Adze k'əɲɪdɪ)

Goba talked about incorporating activities that participants can engage with on an internal level:

But some of the, and of course, I'm a psychologist too so some of the internal stuff I think is important too. Make connections, find activities that you feel are going to make connections internally. (Goba)

She later explained that when activities connect internally, they can resurface during health care encounters with patients and clients:

... I think it's some of that internal piece is what I will, what will stay with me, what will come back to me, what forces me to try to rise to a higher ideal of cultural sensitivity when I'm sitting with a forty-seven-year old Dene woman that's struggling with depression. (Goba)

Intervention Design and Organization

This section includes sub-themes that relate to the design and organizational aspects of the pilot intervention. The sub-themes of sequence, post-training support, timing, pace and length, as well as resources and activities reflect factors that were identified as the most relevant to participant learning and engagement, including areas for improvements.

Sequence

Sequence refers to the order of individual training sessions, as well as feedback and recommendations leading up to the event and post-training. Feedback about the sequence of content was generally positive. The following participants explained:

... I think the structure of the way that things were presented, with the background from zah hehga and her history on the history of the Northwest Territories and generally in Canada and the settler population, with that being a segway into zahtl'ákw'a's personal experience so that, you know, this isn't just stuff that happened to people far removed and long ago from here. This is stuff that is real today for patients in your office. And then onto zahtl'ákw'a who was a fantastic coordinator about facilitating the discussions and helping it through that people talk with zahtl'ákw'a and others about the experience through there. So I think that whole integration of those pieces was very well done and the way it was laid out was fantastic. (Naətsi)

... and then hearing also individual stories helped to, at least for me, add, or fill in, or translate from the sort of historical background into what does this actually mean for people, what does this look like. (Bek'áhka)

One participant appreciated the lead up to session four, *Building Culturally Secure Clinical Practice*, as racism is not a topic you can dive into right away:

It was extremely well organized and I would say that because of the order in which things were discussed. I think if we broke right into racism conversations, then I don't think I would have necessarily have had been warmed up to do that. Like, it's sort of something you need to work toward and not necessarily right after breakfast, crack it open. And very helpful to have the historical context presented initially, bringing it into a personal level and then expanding from there. So, I thought like it was like a wonderful flow... (Bek'áhka)

Post-Training Support

Participants embraced cultural safety and understood that to be successful, proper supports and learning opportunities must be in place post-training. One participant suggested the pilot intervention as an initial orientation for staff, followed by less formal learning opportunities:

I think they need to think about how could they sustain these conversations, like throughout in the workplace, so you start with an orientation but how do you bring people back to engage them at other times to have these conversations because, you know that everybody goes for an orientation and that's it. And then they go out and they don't practice. So, what, what is the responsibility of an organization to make sure that those languages are, you know, sustained... So, it could be somebody coming to speak, you know as a lunch and learn. Other times, it could be a mandatory thing. So, it doesn't have to be as structured as this one-day thing. (Yát'a)

Other ideas included the formation of a committee and offering cultural safety training annually:

So, I think our biggest challenge is to find consistency... whether we have the workshops yearly with... perhaps we could have small committees or small meeting groups that meet a couple times via teleconference throughout the year... I meet on so many meetings whether it's policy emergency preparedness... But we don't meet for, for that [cultural safety], and yet we're providing health care services in Aboriginal communities... but really, in the idea of, of somewhat course corrections is the right term to use, but consistency and keeping it alive for us. (Goba)

One participant, who resides in a small community outside Yellowknife, expressed feeling isolated and far-removed from the other participants upon returning home. Without proper post-training supports, one's ability to practice cultural safety may be impacted:

... but looking at going back to a community having had that experience [participating in the training] and not having anyone else that has shared that, at least direct from my building, there was one other person here, and kind of feeling a little bit of, I don't know,

isolation from others in terms of a passion for this. I don't think it's going to die out, it's not something that's going to go on the back burner for the rest of my life but it makes it a little harder to translate that back without some sort of local partner or someone that I can draw upon. (Bek'áhka)

As a solution, she suggested adding additional time on the agenda to discuss next steps and form supportive networks:

.... something that did come to mind at the end of the session was that, if time had allowed, speaking a little bit more about where we go from here, and making connections to have sort of an ongoing plan or, if later on in my practice, I come across something that I think is... to have maybe a couple of people to bounce those ideas off of to see if they've come across the same issues. (Bek'áhka)

Goba also raised a similar concern about the need to think about next steps as a way to sustain cultural safety:

On my feedback form, I had indicated that, you know, where do we go from here and often when we attend those, those types of workshops, people say "okay, well we don't want to drop the ball and, you know we come together" and we get so excited and then we go back to our routines. (Goba)

To help participants apply cultural safety in their practice post-training, one participant suggested finding a way to build small tokens into the intervention. The token, as a concrete symbol of cultural safety, may elicit memories that will assist with the provision of culturally safe care:

And so, it's, you know, 'cause we want to take it back to our office. For me, it's always about outcomes. You know in, in some manner maybe not in all, you know, research way or numbers but, you know, back in somewhere we passed out pebbles... a pebble in your hand. If you take that back to your office it's something tangible that reminds you of that two-day experience and reminds you of the importance. I take the cultural piece so important but I also get extremely busy and you know, and I know that at times I don't function as well as I could have within another culture. So, yeah, I just, any, any symbols or tangible things that we could bring back to our office, a feather? (Goba)

Timing, Pace and Length

Feedback about the length of time allocated for the entire workshop was mixed:

I think two days is an excellent, at least starting point for engaging. (Bek'áhka)

For me, I probably had a sense of - we were just scratching the surface of things. I wanted to unpack around my program area, so I could have probably gone all week. (Gorek'ale)

The quote above, particularly the point about time, highlights an important factor related to what facilitates or hinders engagement with challenging subject matter:

So, I think part of that process is often resistance from participants - right? To acknowledge their own privilege and you know racism that they've been carrying around and then guilt, that's all part of the normal process... and so, how do you make space for that in two days? And not just either lose people or leave them in the guilt place, or whatever. (Gorek'ale)

On time and a flexible agenda. Many participants appreciated the flexibility of the agenda, which provided time and space for discussions to evolve:

Well, what can you say, it was well organized. You know we were picked up on time, delivered on time, the schedule was kept on time, with, yet, with having the flexibility, you know if things needed to kind of telescope one way or the other. (Sa)

I think just having that flexibility to go and kind of save the sessions themselves more as a general guide to the discussion rather than a fixed time... So, I think the length of the day is good and the general structure, but trying to slice and dice those down to a one-hour or a forty-five-minute piece, I don't think gives it justice. And I think people have to realize that when you go that you're here for the day, we will get through the topics, some more in depth than others, depending on the wishes of the audience and the way that the discussion is going. (Naətsi)

I do feel like it was a nice balance of following the agenda but also not being rigid around that and letting conversations unfold. (Gorek'ale)

Pace and length. The pace and length of sessions were deemed appropriate as several participants noted their attention was maintained:

Very well balanced. It had this really magical combination of, of thorough comprehensive overview, but then not being too much and also like time just passed and it was just like, it's gone, what, it's lunchtime? So, I think that for me is an indicator, like if I'm not getting fidgety and I'm not looking at my watch or wondering if I have to go to the bathroom, like none of those things happened. And I'm not very good at sitting still usually, so that was I think very, the length of time was very appropriate. (Bek'ahka)

I think the pace was fine. Yeah, it held my attention, I didn't find, you know, myself wandering. I think we switched up often enough that it kept our interest. (Goba)

Resources and Activities

Reading materials. During the workshop, participants were provided with binders of optional readings selected by ʔah hehga. Some participants expressed enthusiasm about them:

I remember looking at it and thinking, this is amazing and I can't wait to unpack it.

(Gorek'ale)

Participants also indicated the readings were helpful to deepen their understanding of the content and to help share information about the training with staff:

Interviewer: *Okay so you read the resources, did you find them relevant?*

They were! Because they spoke to what we discussed and more in depth. Because a lot of this we kind of breezed through, there was one that was kind of on the history, kind of this area, which was interesting. (Whê)

Yeah, they were very relevant and they were useful in that, sometimes when you're presented a lot of information, you're not sure if you'll retain enough of it; most notably, when reporting back to staff to try to share what you learned. Having those resources to call upon can not only help improve the depth of your understanding but also just something to look at and think what, what was that thing she said again? And you might have some general feelings in the sense of what was discussed but having something to look back on also reinforces that and makes it a little easier to share with others. (Bek'áhka)

Despite an overall interest in the readings, some participants had not read or had not recently referred to the readings for reasons related to other priorities within the workplace:

...And I still have not read it... That's time constraints and getting around to do stuff but I, I don't think I'm unusual in that, many people in this, that are at these meetings have got a lot of other things on their plate to read. Doesn't mean that this is [not] a priority, but there, the incentive or the motivation for them to read this is extremely low... I still have it on my list of things to read. (Naəts!)

Several suggestions were made regarding the reading resources. One participant requested that facilitators reference the reading materials during the training itself:

So, I think, yes. Maybe one suggestion would be if that, if those resources were, and maybe I just can't even remember then this did happen, but if they were referenced a little bit more in the workshop?

Interviewer: *Okay. That's a good suggestion.*

Like incorporated just so it's a little bit more on our mental library. (Gorek'ale)

Another participant suggested that facilitators provide their personal reading recommendations to participants:

I don't know if this is applicable, but in terms of after the fact reading, if there was material that they recommended for a bit more, if there was one thing that they had come across, because there's so many books out there it's sometimes hard to pick where to start. So, if that would be something they wanted to share, and they said check this out if you want to learn more, or here's some information about whatever, I don't know what it would be but something they felt was important for someone outside of that experience to know. (Bek'áhka)

Providing the resources in USB format was another suggestion:

I would say that the USB format is something, like I still have the hard copy. But the USB ends up being something that is easier to travel with. So that would be the only thing is if it was a lot of work to create the binders with the printouts, like for myself I think that the, because the USB is a little more compact. It would be something I would keep longer. (Bek'áhka)

Training package resources. One participant suggested developing a cultural atlas of Indigenous groups in the NWT as a resource. This can be beneficial to all clinicians, particularly for those who were born and raised in the NWT:

And a cultural atlas... I think that when I went to the cultural training for the GNWT [Government of the Northwest Territories] they just said cultural groups and I, you know born and raised in the Territories, I know my area here but I don't know a lot about the Territories, like. So, you know the Gwich'in lives in this area, and who are the Gwich'in, and what does, you know. That kind of stuff I think is really... Yes, yeah that's what I thought could be developed as part of the training package. (Adze k'ənıdı)

The resources provided for participants in the workshop can also serve as educational materials for their patients. For example, the following participant describes how community people are not always aware of the intergenerational effects of colonialism and residential

schools and suggested developing educational materials such as worksheets, DVDs or CDs that be used for educational purposes:

The theory's only so good for me as, yeah what do, I do with it when I'm in a room with a person... resources for me would be, I don't know, backgrounders that, you know because not only are, you know, people coming up from the South don't know this, a lot of local people don't really, because the people who went to residential school don't talk about it. You can be dealing, with like a grandson or something and they don't understand that what they're facing is the impact of colonization and inter-generational trauma. So, I don't know, a worksheet, general information that you could hand out too... I don't know what kind of worksheets you guys might come out of it with it but those are the kind of things that I use in my work. Background information and possible worksheets. The DVDs, the, you know CDs, that would be good too... it's not only for my learning but, you know that could be something that I use with clients so... I might, you know, at different times be doing like community presentations and well, maybe you have something on your DVD, if there's a five-minute spot that I can show at some presentation at school or with the community and then we have a chat about it. (Sa)

Overall Feedback

This section includes responses pertaining to the participants' overall experiences of attending the pilot intervention as well as sub-themes of positive experiences and target audience.

Positive Experiences

A major pattern in the data was the positive comments about the workshop. Positive comments related to workshop content, the facilitators, and the manner in which the workshop was organized:

I think it was great... I enjoyed the entire experience. (Naətsi)

I really am happy that I was part of it and if you could pass on my appreciation to those who organized it and those who presented it and I, I really appreciate it and yeah. (Sa)

I would like to say that I think it was awesome, I think it's so needed... (Gorek'ale)

Well, what I did remember more than anything else is, this is twenty-some years too late, there used to be a cultural or an orientation. And this was a better than anything I've done before, it was better done. (Whé)

I think it was well organized, I was very appreciative, very appreciative of it. I was excited to go, I want to make sure that I'm always included in any future endeavors that are similar. (Goba)

... I just admire that you guys [Department of Health and Social Services] are taking this on; this is absolutely amazing and inspirational. (Bek'áhka)

Target Audiences

Participants provided helpful ideas about who else could benefit from the training, with one participant suggesting a traveling format to ensure all staff can participate:

I would say you need to do this with everybody. You know and I flip between, do you catch those of us that have been here forever or do you just start with everybody's new – got to do it and catch up on the old people at the same time. (Whé)

Well, I guess for me... the picture I have is wouldn't it be nice if all the people that I work with were there. (Sa)

I feel like everyone should have that experience, that's willing of course, if they're unwilling then, but even unwilling people it might be an idea just to see if they'd take anything away from it... I feel as if you're hired to work in the North that you should, like have to go. Or at least make the time to experience that stuff. I feel like anything less than that is inappropriate. (Bek'áhka)

Contexts

This category includes responses that do not directly relate to the interview questions but represent factors that influence the provision of culturally safe care. These factors are largely outside the control of clinicians and include the sub-themes of: structural barriers to care, NWT government, as well as opportunities and strengths.

Structural Barriers to Providing Culturally Safe Care

Busy schedules. Working with patients and clients in a culturally safe way requires time to build relationships. Several participants identified busy schedules and lack of available time as barriers to providing culturally safe care:

So, whether its Aboriginal people or any people, I think it's, it's that time it takes to really understand the context and the life experiences and what people bring to that

relationship... and people get caught up in the busy-ness of work and life and it gets in the way of really, honestly providing the care and the support for people. (Yát'a)

Even clinicians who understand the importance of cultural safety, are restricted by time issues:

... to ensure those course corrections, because people [clinicians] are out working in the field, they're working in their, you know, their health authorities and it's important to them but they're also very very busy... (Goba)

Systemic racism. Several participants identified systemic challenges related to racism.

These include the prohibition against burning tobacco in facilities, lack of available traditional healing services for Indigenous patients and clients, and a lack of Indigenous physicians working in the NWT. I have referred to these as elements of 'systemic racism' because they represent the ways in which the health care system has failed to adopt Indigenous strategies to address inequities related to Indigenous health and access to health care. The following participant suggests that denying Indigenous peoples the right to burn tobacco in facilities for healing purposes is systemic racism:

But it's systemic racism... we have been trying to work on as much in policy in this facility for ten months and then we get something that comes up that says at no time tobacco is to be burnt in this building... to me is systemic racism... you are denying people the right to practice and to heal in their own way. (Adze k'əṇḍi)

Another participant expressed her inability to support several of her clients' requests for traditional healing services:

... I've had a couple of people having an interest in traditional medicine. I've not been sure how to navigate that, where to look, how to access some of those services, and the digging that I have done, I had learned from some of our local folks here that there are protocols in place. (Bek'əhka)

According to the following participant, cultural safety is facilitated when physicians share similar cultural backgrounds and experiences as their patients. Unfortunately, not only are Indigenous physicians markedly absent from the current health care system but the system may not see this gap as a priority:

... in our current system, right now, I think we are at zero [Indigenous physicians] across the board, both in primary care and in specialty care... I think that is one of the ways to addressing the problem personally, can I prove that? No. But I think all of the issues we were talking about... that shared experience now goes away when you have people from the same culture, because you've got that same cultural experience. So, then you look at the [Indigenous] people who are in stream coming up on either return of service agreements... from the North and have gone out to [medical] school, I think we're at... about five or six with potential ability to return to the North. I worry in our current environment that we don't create space for them. (Naətsí)

NWT Government

Several participants noted that the Government of the Northwest Territories should prioritize and endorse the development of cultural safety training for staff:

So, I look at it sort of like course correction and so for me it's pivotal that we come together, that we, well first of all that we elevate it in terms of importance in our work from a government perspective, other agencies as well, but I think if we're going to be working within the government then we have to elevate that importance. (Goba)

GNWT [Government of the Northwest Territories] should really have something. You know they've got all kinds of things on you know writing proposals and all of this. We all interact with people, and a lot of people are from here, and a lot aren't from here, and I think it's good to have a mix of both. (Whé)

I would like to think if, if the government has not done anything like this that it would be something that they would continue... High priority, honestly. I really would. Because I think a lot of people who are working with the government seems to think they really have a good understanding of the Aboriginal people and, honestly if you really ask them, okay do you really? Can you tell me about it? They may not be able to put that into words. (Yát'a)

Opportunities and Strengths

According to Adze k'əṇḍi, conditions to advance cultural safety are already in place.

Having long-time Northerners in senior leadership positions more easily facilitates buy-in:

I just think the North has so much to offer and we're in some ways so much further ahead because our connections are so close to the Deputy Minister, we're close to the Minister, we have that support, we have long-term Northerners that are in very important positions that would support this [cultural safety training], right? (Adze k'əṇḍi)

In addition, as an Indigenous clinician and bureaucrat, Adze k'ónıdı highlights the challenging nature of influencing change at the government level. Despite this, she advocates for Indigenous people in government who possess unique perspectives of “living in both worlds” and applauds the Aboriginal Health and Wellness division (now referred as Indigenous Health and Community Wellness) of the Government of the Northwest Territories as change agents:

I think of how difficult it's been at times being an Aboriginal clinician and I know both worlds – I've lived in the world of this community, born and raised here, lived in that traditional family lifestyle. And then also raised in really the bureaucracy of working for the government for thirty years and I know how difficult it is to change things... we need people that are like, can be that bridge... But you also have to have a group of people in the government, and I think that's what you guys are doing there with the Aboriginal Health and Wellness [a division in the Department of Health and Social Services], that really knows this and supports it and, you know makes it come alive, right? (Adze k'ónıdı)

Summary of Chapter 3

This chapter provided an overview of the experiences, perceptions, and responses of eight participants who attended a pilot cultural safety training intervention in the NWT. In general, participants were satisfied with the design and delivery of the workshop. At the same time, challenges concerned gaps in content, conceptual confusion, and how participants, in some cases, negatively responded to the content. Participants also highlighted what aspects of the workshop facilitated their learning about cultural safety, while providing recommendations. In the next chapter, I will discuss these findings in relation to existing literature, examining the responses of learners as they experience training programs in cultural safety or otherwise similar programs.

Chapter 4: Discussion

The findings from this study will assist the Department of Health and Social Services as they continue to develop cultural safety training for staff in the NWT. While this thesis serves practical purposes, it also contributes to current knowledge in the field, with respect to how participants, namely non-Indigenous clinicians, experience and respond to cultural safety training. I have organized the discussion around three key workshop themes: learning, challenges, and relevance; and explore relationships with existing literature where possible.

Learning

The first theme that will be explored in this discussion is the learning that took place as a result of the intervention. For the most part, the content of the workshop seems to have contributed substantially to the participants' learning.

In terms of knowledge acquired, the findings suggest that participants gained critical knowledge about Indigenous history and colonization, as well as racism and privilege in health care, all of which are important learning outcomes for cultural safety training (Bennett, 2018). Learning about the contexts in which Indigenous peoples live, particularly colonial history, is foundational in cultural safety training. It aims to address a pervasive gap in knowledge about Indigenous history in Canada, while at the same time correcting the gross misrepresentation of Indigenous peoples “as ‘inferior,’ ‘uncivilized,’ as ‘savages’ and even as ‘not fully human’” (Ward et al., 2016, p. 32). Pedersen, Walker, Paradies, & Guerin (2011) report that provision of “accurate information” decreases prejudiced beliefs about Indigenous peoples. Similarly, health care providers may be motivated to address their biases when presented with evidence of racism in health care and that biases are attributed to disparities (Burgess, Ryn, Dovidio, & Saha, 2007).

However, Pedersen et al. (2011) also acknowledge that providing information, while critically important, does not solely change behaviours.

Several positive outcomes reported in the findings are linked to the contextual information delivered at the workshop. Participants indicated more confidence in providing Indigenous patients and clients with appropriate care based on an understanding of the contexts in which they present themselves. Several participants indicated increased awareness of and empathy about residential school experiences. In terms of empathy, research indicates that enhancing empathy among health care providers is effective in improving relationships and interactions between patients and health care providers (Burgess, van Ryn, Dovidio, & Saha, 2007). Empathy involves cognitive (perspective taking) and affective components (emotional responses). In other words, “perspective taking arouses affective empathy, and affective empathy facilitates adopting the other’s perspective (Burgess et al., 2007, p. 884). This suggests that hearing directly from Indigenous peoples about their residential school experiences builds empathy among clinicians.

The findings reveal that many participants understood self-reflection as important to practicing culturally safety. Self-reflection is central to cultural safety because it tends to move clinicians from knowledge to action (Bennett, 2018; Tomascik, Lavallée, Diffey, Lafontaine, Barnabe, Bourassa, Dignan, & Reading, 2014). Because cultural safety rests on the need to address inequities sustained by the health care system, including the behaviours and attitudes of staff, clinicians must first understand how power and privilege at individual and institutional levels operate. Both require critical thinking.

At the individual level, critical thinking and self-reflection (also known as reflexivity or self-awareness) involves examination of one’s identity and how social location positions one in

the context of Indigenous relations – whether in health care settings or as part (or not part) of mainstream society (Delany et al, 2018). Cushman et al. (2015) describe identity as dynamic and multi-dimensional. These authors use intersectionality to explain that individuals hold multiple identities that range from positions of privilege to those that are marginalized – all of which “intersect and interlock in essential ways with systems of power, dominance, and oppression” (p. S133). Thus, self-awareness “includes exploring such facets of self as race, ethnicity, gender identity, sexual orientation, physical abilities, socioeconomic status, and cultural background among others” (Bender , Negi, & Fowler, 2010, p. 35). Reflection and recognition of privileged identities informs action whereby clinicians actively challenge stereotypes and inequities (Tomascik et al., 2014). As noted in this study’s results, clinicians demonstrate their own process of self-reflection, including gaining a sense of social responsibility and their own role in improving Indigenous health outcomes.

Exploring and becoming aware of biases is of particular importance in the context of self-reflection and cultural safety because bias and other forms of racism, which often occur unintentionally (Burgess et al., 2007), are sources of inequity for Indigenous peoples. For example, research indicates that implicit racial stereotypes held by health care providers influence their delivery of treatment and care options (Burgess et al., 2007). Other research demonstrates that physicians have an unconscious preference for white patients (Metzl, Petty, Olowojob, 2018). Self-reflection of biases in practice therefore “prevent unconscious attitudes and stereotypes from influencing the course and outcomes of clinical encounters in negative ways (Burgess et al., 2007 p. 882). As indicated in the findings of this study, clinicians understand the importance of examining racial biases and concepts of privilege that are associated with being white. This suggests some success associated with this intervention, as

Bennett (2018) reports that people of dominant groups “do not spend much time thinking about what it means to be part of that group, and what benefit and privileges it brings” (p. 17).

Reflecting about the power and privilege of the health care system involves a critical analysis of “how taken-for-granted practices, policies, and research approaches can inadvertently create health inequities” (Gerlach, 2012, p. 152). The dominance of biomedicine, including the ways in which mainstream health care have privileged western notions of health and healing while excluding Indigenous values and conceptions of wellness (Greenwood et al., 2017), is also examined (Varcoe & Browne, 2014; Gerlach, 2012). An anti-racism approach similarly analyzes the power of societal structures, their historical underpinnings, and how they benefit some individuals and groups and not others (Came & Griffith, 2018). For some, anti-racism approaches are important aspects to include in cultural safety training (Churchill et al., 2017). Through exploration of concepts such as “social suffering” and “post-colonialism” in the workshop, participants demonstrated a shift in their own colonial perspectives. Findings from this study also suggest that clinicians are aware of the systemic barriers that prevent culturally safe care, such as the unavailability of traditional healing services for Indigenous patients and clients.

Experiential learning emerged as a key theme, whereby participants became more deeply connected to each other and the process of the workshop through smudging and the fire feeding ceremony, as well as hearing about first-hand Indigenous experiences of colonialism and a demonstration of traditional medicines. Indigenous facilitators were particularly impactful because they embodied or put into context the historical information presented earlier. In fact, these aspects of the workshop garnered the most positive response.

Other studies have reported on the value of providing experiential learning opportunities to participants in cultural safety training. For example, a scoping review of cultural competency and cultural safety education and training in Canada, similarly found experiential learning to be a valuable teaching method, particularly those involving Indigenous communities (Guerra & Kurtz, 2017). Furthermore, according to Vogel (2018) experiential learning involving Indigenous peoples, such as making space for Indigenous knowledge, will help to break down the long-standing colonial beliefs that Indigenous knowledge and medicines are “witchcraft”. As one surgeon notes, “smudging, ceremony, singing and even most of the medicines don’t interfere with most surgeries I do... We’ve got to break down that fear” (Vogel, 2018, p. E778-E779). This suggests that inclusion of Northern Indigenous facilitators and activities, like the traditional medicine demonstration in cultural safety training, challenge the dominance of the biomedical model.

Although participants demonstrated a preference for the Northern Indigenous and Northern facilitators, this does not indicate a personal dislike of the Southern facilitator. Rather, it was the social location as a “Southerner” that seemed to be a limitation. This is explored later in the chapter. The Northern Indigenous facilitators were highly regarded by participants who expressed that listening to their experiences and stories, particularly about residential schools, were impactful. Storytelling was highlighted as an important method of knowledge translation. This is supported by a study by Shah & Reeves (2015), which found that Indigenous instructors sharing of their stories in cultural safety training contributed to the success of the program. As well, ceremony was generally regarded as a respectful, calming, and grounding approach. This suggests that facilitators from the North may contribute to a safe learning environment for learners.

The findings indicate that logistics and design features of cultural safety workshops are important to learning, particularly in terms of appropriate content, sequence, pace and length of workshop sessions, as well as a flexible agenda. The venue of workshops seems to be especially important, and there was a preference for natural environments that facilitate exercise, unplugging from work and networking. This particular land-based format appears unique in comparison to the literature. Vogel (2018) identifies lecture-based model as a downside when applied to cultural safety training.

Challenges

The findings of this thesis suggest some confusion about the difference between cultural practices and cultural safety. According to the literature, there is considerable confusion regarding concepts of culture and cultural safety in health care (Willen, 2013; Gerlach, 2012; Kirmayer, 2012; Brascoupé & Waters, 2009; Browne et al., 2009). Although culture is dynamic and ever shifting, and something in which everyone participates, we must also recognize that historical, social, political and economic factors also influence culture (Browne & Varcoe, 2006). Browne et al. (2009) contend that “without a solid understanding of how culture itself is conceptualized in cultural safety, the risk lies in unintentionally implying that what is needed is more cultural knowledge...inherent to particular groups of people” (p. 173).

The findings suggest that, without a critical understanding of cultural safety, health professionals are at risk of focusing narrowly on learning about Indigenous cultures without acknowledging their own social location and biases, or the root causes of inequities like colonialism and racism, and how they manifest in practice within institutions. Browne & Varcoe (2006) explain how cultural sensitivity approaches can overlook contextual factors in practice: “interpreting eye contact (or its avoidance) as purely ‘cultural’ overlooks the influence of power

and racism on how people relate in social circumstances and the extent to which avoidance of eye contact may be a strategy for some” (p. 164).

To address these challenges, it is important that cultural safety training workshops clearly distinguish between these concepts; participants must understand that cultural safety does not focus on learning about Indigenous cultures and practices (i.e. cultural sensitivity). Ensuring that consistent terminology or concepts are used throughout the training, including in the promotion of the event, helps prevent confusion and facilitates learning.

Adverse, emotional reactions to the content of cultural safety training can greatly affect learning (Churchill et al., 2017; Browne et al., 2009). Such content typically includes colonial history; understanding the social determinants of Indigenous peoples’ health, including distal determinants of colonialization and racism, and how they create power differences and inequalities in Indigenous health outcomes and access to health care. Moreover, other such content involved power and privilege in relation to Indigenous peoples, including concepts of settler colonialism and white privilege; and the skill of critical self-reflection or reflexivity to identify, examine, and address dominant worldviews, biases and privileges (Churchill et al., 2017; Ward et al., 2016; Shah & Reeves, 2015; Reading & Wien, 2013).

There is no shortage of research describing negative emotional responses to content related to privilege, race, racism, culture, and ethnicity (Jacob, Raymond, Jones, Jacob, Drysdale, & Isaacs, 2016; Richardson, Carriere, & Boldo, 2017; Sue, 2013; Kowal, Franklin, & Paradies, 2013; Watt, Curtis, Drummond, Kellogg, Lozano, Nicoli, & Rosas, 2009; Sonn, 2008). These topics, which challenge previously, held dominant beliefs could seem to personally implicate participants in the perpetuation of Indigenous inequities. While any one element of cultural

safety training content can elicit negative responses, the intensity of these feelings can be elevated in response to the range of difficult topics covered.

Not surprisingly, the findings of this study are consistent with other research examining responses to cultural safety training (Churchill et al., 2017; Richardson et al., 2017; Browne et al., 2009), as well as training related to privilege and power, race, racism, culture, and ethnicity, which address inequities of both Indigenous and those racialized as non-white in Canada, U.S. and Australia (Jacob et al., 2016; Sue, 2013; Watt et al., 2009; Kowal et al., 2013; Sonn, 2008). These studies demonstrate that trainings such as these involve emotionally charged subjects for learners who demonstrate a range of emotions: anxiety, avoidance, blame, cognitive dissonance, defensiveness, discomfort, guilt, helplessness, invalidation, resistance, disengagement, and unease (Churchill et al., 2017; Richardson et al., 2017; Jacob et al., 2016; Kowal et al., 2013; Sue, 2013; Watt et al., 2009; Sonn, 2008; Browne et al., 2009). These reactions are also noted in the literature as “white fragility” expressed by the dominant white population (Bennett, 2018; Davis et al., 2016). Several adverse and noteworthy responses were identified in the pilot workshop interviews, two of which were exhibited by the same participant. While this is positive, the fact that participants volunteered to participate in the workshop, and consequently my study, suggests that participants were already interested and willing to learn more about and discuss these topics at the workshop and with me. These responses may not be representative of clinicians in the NWT and elsewhere.

Avoidance

As noted in this study’s results, some participants diverted the discussion to a more ‘palatable’ topic, while others attempted to distance themselves from the label of racist by claiming to “treat everyone the same”. Both of these responses appear associated with denial,

privilege, and even fear. Moreover, responses such as these are the result of powerful dominant discourses that both discourage and mediate the way in which these types of discussions should occur and unfold (Sue, 2013). For instance, Sue (2013) describes that entering in race discussions is considered a social taboo. This context presents significant challenges for engaging in real and honest conversations about racism, which is essential for practicing cultural safety and ultimately tackling inequities.

One powerful way in which race discussions are mediated is through the “treating everyone the same” approach. On the surface, this sentiment might appear to be a reasonable, if not a commendable attempt at establishing equity (Tang & Browne, 2008). Yet, this response conceals an approach referred to as colour-blindness, which minimizes differences among people and implies a personal absence of bias or any other forms of marginalizing practices towards Indigenous patients and clients (Tang & Browne, 2008; Ranzijn, & McConnochie, 2013; Reading, 2013; Sue, 2013). Minimizing differences essentially denies the social construction of racial categories and the fact that people are treated differently based on those constructions. For example, we know through research that Indigenous peoples experience racism because of their social classification– this is a privilege that people categorized as white never encounter (Reading, 2013). Similarly, Ranzijn et al. (2013) describe colour-blindness as an “aspect of white/unearned privilege” (p. 448). The ability to deny differences, reinforced by dominant discourses, also highlights the privilege associated with this concept. According to Sue (2013), a fear of appearing racist appears to be a main motivator behind adopting a colour-blind attitude.

Finally, dominant discourses of egalitarianism and colour-blindness actually work against social justice efforts because they maintain the status quo by preventing the learner from engaging in self-reflection and understanding oppression; key ingredients of cultural safety.

The need to discuss and openly address challenging topics requires doing the hard work. This sentiment extends to the need to discuss settler colonialism and explore the colonial history from which settler Canadians (whether born in Canada or not) have benefited, and continue to benefit, from the forced displacement and continued oppression of the original inhabitants (Barker, 2009). Further, because the term settler “recognizes the historical and contemporary realities of imperialism that very clearly separate the lives of Indigenous peoples from the lives of later-comers” (Barker, 2009, p. 329), it is especially relevant in the context of cultural safety as it also foregrounds historical and contextual factors that shape Indigenous peoples’ lives.

The other point to address here is the act of avoidance. Cushman et al. (2015) contend that identities associated with power and privilege in mainstream society are often those that are unrecognized, ignored, denied, and uncomfortable to hold. Further perpetuating the avoidance and silencing of power and privilege, particularly as it relates to racialized identities, is what Sue (2013) describes as a “conspiracy of silence”, which is characterized by dominant discourses of politeness and the aforementioned colour-blindness. This may help to explain, in part, why some participants avoid subject matter that is associated with their advantaged identities such as settler colonialism or white privilege.

These findings point out the need for serious consideration about how much time is required for staff to address unconscious bias and colonial mindsets, and the ability to critically recognize the dominant discourses operating within themselves and health care. Browne et al. (2009) stress the importance and need for clinicians to understand issues that are core to cultural safety “such as the need for nurses to reflect critically on issues of racialization, institutionalized discrimination, culturalism, and health and health care inequities” (p. 173).

Davis, Hiller, James, Lloyed, Nazca, & Taylor (2016) argue that “without the critical

learning and unlearning necessary to unsettle Canadian identities and name settler colonialism, reconciliation initiatives may succeed in making settlers feel good about themselves while failing to promote substantive change” (p. 11). In fact, discomfort and feeling unsettled is identified in the literature as a necessary step in a learner’s transformation and developing critical awareness to confront one’s biases or privileges (Davis et al., 2017; Ranzijn et al., 2013; Sue, 2013; Thackrah & Thompson, 2013; Durey, 2010; Sonn, 2008).

A number of studies describe or promote designing training programs to “make discomfort part of the learning process” (Churchill et al., 2017; Cushman et al., 2015, Guzder & Rousseau, 2013; Ranzijn & McConnochie, 2013). For Guzder & Rousseau (2013), discomfort not only serves to enhance learning but also mimics the discomfort and uncertainty of clinical encounters; “the decentering process of the participants needs to be sufficiently unsettling to allow them to experience the uneasiness of the clinical moment (p. 350). However, some literature cautions that a balance be struck between managing participant discomfort and not “coddling” non-Indigenous participants as this reinforces unearned privilege (Churchill et al., 2017; Ranzijn & McConnochie, 2013).

Blame

As noted in this study’s results, while acknowledging that information about residential school experiences can be extremely informative, learners can sometimes blame Indigenous peoples for not always sharing their experiences. These responses are indicative of an unwillingness to turn the lens inward, to examine one’s own privilege and rather, a desire to focus on Indigenous peoples’ presumed responsibility for educating non-Indigenous people about our shared history. Irlbacher-Fox (2014) argues that Indigenous peoples “are not responsible for directing, educating, welcoming, or creating the circumstances for non-

Indigenous people to decolonize” (p. 153), as they are fully capable of and responsible for taking on that task. In terms of incorporating Indigenous peoples as facilitators in training programs, researchers examining the challenges related to teaching cultural safety curriculum stress that organizers/curriculum developers must find a balance between respectfully involving Indigenous peoples and not burdening them with sharing their personal stories (Delany et al., 2018; Davis et al., 2016). This suggests that cultural safety training must carefully consider this balance and ensure the proper emotional and spiritual supports are available for Indigenous facilitators should they decide to share their personal stories.

The findings of this thesis study suggest that Indigenous story-telling is an effective tool in cultural safety training. Richardson et al. (2017) explains that, within Indigenous contexts, receiving stories is like receiving a gift. Hence, what responsibility does the individual have with the gift of story? The authors offer a quote by Thomas King that reciprocity “invites us to consider how we will live our lives differently now that we have heard the story” (Richardson et al., 2017, p. 191). This is an important perspective to apply to cultural safety training, particularly if Indigenous peoples are willing to share their residential school stories.

The interim report of the Truth and Reconciliation Commission [TRC] of Canada (2012) described how “some people were so overwhelmed by grief and emotion that they could not complete their statements... these Canadians have been carrying a tremendous burden of pain for years” (p. 7). The TRC also reminds us that residential school survivors had to demonstrate tremendous courage to tell their stories before the Commission. Yet, the emotional distress Indigenous peoples can experience when sharing residential school stories should not be understated. Otherwise, learners might come to see these and other traumas of colonialism from a detached, rather than an empathetic, perspective.

Practical Strategies

Although the participants of this study were satisfied with the content of the workshop, some noted a gap in concrete actions for applying cultural safety in practice. The desire for practical strategies may be a symptom of the complex nature of cultural safety. As described by Guerra & Kurtz (2017), “the battle now raging finds us seeking to effectively translate the wisdom of a culturally safe approach to humanity into the subtlety of everyday encounters, where such humility and respect have been long forgotten” (p. 140). As found in this study’s findings, providing examples to understand better the link between content and practice appears to be one way to address this gap. There is evidence to suggest that practical steps at point-of-care can have positive effects on patient and client experiences (EQUIP Health Care, n.d.); however, Delaney et al. (2018) cautions that learners must also focus on “processes required to transform such knowledge into establishing relationships rather than how to transact a healthcare service by one person for another” (p. 267). Similarly, learners must understand that cultural safety “cannot be neatly packaged or discussed in the knowledge-translation process as a concrete set of standards for practice” (Browne et al., 2009, p. 175).

Most Relevant Aspects to Enhance Learning

Safe Learning Environment

One of the most important themes to emerge from the findings is the need to provide both Indigenous and non-Indigenous participants with supportive and emotionally safe learning environments. These and other findings clearly indicate that the content of cultural safety training has the potential to elicit strong emotional responses. In light of this, the need to provide safe learning environments to learners cannot be understated. As described by Willen (2013), “initiatives that ignore the powerful emotional valences associated with culture, race/ethnicity,

and other forms of difference do so at their peril – and at risk of undermining their fundamental objectives” (p. 258).

Non-Judgement and Mutual Respect

Study participants described feeling respected by having opportunities to share in discussions, without worries of being dismissed or feeling judged by the other participants or the facilitators. This finding suggests that, not only do learners need to feel safe contributing to discussions, but that time and space for these discussions are important priorities in cultural safety training. The need for safe learning spaces, particularly in the context of cultural safety training, or content related to cultural safety (i.e. colonization, power and privilege), is well documented in the literature (Vogel, 2018; Churchill et al., 2017; Thackrah & Thompson, 2015; Guzder & Rousseau, 2013; Llerena-Quinn, 2013; Ranzijn et al., 2013; Sue, 2013). For example, a safe space is achieved when learners feel safe enough to ask the question, “what about reverse racism?” without fear of being blamed (Vogel, 2018). “If people feel under attack, they are less likely to listen or change their views. Our results indicate that we need to take into account both people’s affect (feelings) and cognition (thoughts)” (Pedersen, Beven, Walker, & Griffiths, 2004, p. 247).

Findings also reveal a similar connection between respectful learning environments and participants who volunteer for cultural safety training. In fact, forcing staff to attend such training is viewed as potentially disruptive to both learners and facilitators. In the context of mandatory Indigenous Studies in some Canadian universities, McDonald (2016) concurs:

There arises a concern that has to do with the safety of the Indigenous instructors and students who are now mandated to engage with unsettling material in a potentially hostile

and unsafe space with people who either don't want to be there, or aren't ready to acknowledge their own privilege or self-location. (Para 2)

This backlash can have a negative impact on learners who want to be there, as they “tend to feel less safe in sharing their thoughts or engaging openly in the learning experience” (Richardson et al., 2017, p. 194).

Safe Learning Environments for Indigenous Participants

Cultural safety training will affect Indigenous learners in unique ways. In many respects, a safe learning environment for Indigenous participants is determined by the factors already identified. In other words, when non-Indigenous learners feel supported and are willing to engage respectfully in challenging cultural safety topics, Indigenous learners are more likely to feel safe. However, Churchill et al. (2017) argue that support for Indigenous participants must be given priority and organizers must anticipate and plan for the emergence of safety issues specific to Indigenous learners.

Indeed, cultural safety training can put Indigenous peoples at risk of being silenced and the target of hostile behaviours by non-Indigenous learners (Churchill et al., 2017; Sonn, 2008). Training involving content related to race, racism and white privilege could also spark racial micro-aggressions that trigger emotional responses in racialized people such as frustration, anger, and annoyance (Sue, 2013). A study by Sonn (2008) demonstrated the silencing of the only Indigenous student in a class he taught about race, culture, and power. Not only did other students silence the Indigenous student as she attempted to convey racism from an Indigenous perspective but this, in turn, led to her own self-silencing during later discussions to avoid further confrontation.

The example by Sonn (2018) points to an important factor affecting the learning environment for Indigenous participants – the role of facilitators. Facilitators play a critical role in mitigating harm to or silencing of Indigenous learners during discussions involving, colonialism, race and racism, and privilege and power (Churchill et al., 2017). A hands-off or inexperienced approach, during tense moments, can perpetuate the “maintenance of ‘sincere fictions’, beliefs that support the power of dominant groups” (Pasque, Chesler, Charbeneau, & Carlson, 2013, p. 8), which can work against the intention of cultural safety.

The findings lend support for the inclusion of strategies to ensure adequate Indigenous participant representation. Unfortunately, a challenge facing the NWT and other similarly geographically disperse populations is the likely low levels of Indigenous clinicians. According to CBC (2017), as of 2017, Indigenous peoples represented 31 per cent of the entire workforce within the GNWT, which is comprised of departments, divisional educational councils, health and social services authorities, agencies and corporations. While the exact number of Indigenous clinicians is not known, the general statistics indicate underrepresentation. This is supported by the assertion by the only physician in this study, who claimed that, at the time of this study, there were no Indigenous physicians currently employed in the NWT. Thus, larger systemic issues must be addressed in order to enhance the cultural safety of care for Indigenous patients and clients. Other strategies include making the training available to all staff at the Department of Health as well as health authorities across the NWT and/or offering Indigenous-only sessions, as is the practice of the BC Provincial Health Services Authority’s San’yas Indigenous Cultural Safety Training Program (Churchill et al., 2017).

While not revealed in these findings, there is real potential for cultural safety training to “be triggering, re-traumatizing, and/or shocking, especially if it is the Indigenous person’s first

exposure to the content” (Churchill et al., 2017, p. 11). Therefore, providing Indigenous participants with Indigenous-specific supports during and following cultural safety training, such as making Elders and Knowledge Holders available for counsel or following up is critical.

The development of cultural safety training may necessitate conversations about the inclusion of Indigenous learners in the first place. Indigenous learners will have various colonial experiences and understanding of the issues, and may be at various stages of their healing journeys. Similarly, Indigenous peoples hold multiple intersecting social identities (such as socioeconomic status, gender, and sexual orientation) (Tang & Browne, 2008) that influence our perceptions of self and others. Cultural safety training involves content about colonialism and racism, which creates a potential that it may be triggering for some. However, while it can be a shocking experience for an Indigenous person to learn about colonialism for the first time (Churchill et al., 2017; McDonald, 2016), for others, it might be a powerful moment of making sense of one’s life in the context of colonialism (Hall & Cusack, 2018). It might be an Indigenous person’s first time interacting with Elders or learning about Indigenous medicines. As stated previously in the literature review, cultural continuity is a social determinant of Indigenous peoples’ health. For these reasons, it might be best to leave the decision up to each Indigenous person whether or not to participate.

Indigenous Pedagogy & Transformation

Strong indications emerged from the findings that participants attributed Indigenous pedagogical approaches with feeling safe and respected, and in some cases, a sense of healing within the workshop. A study by Richardson et al. (2017) reports a similar finding in which participating in ceremony was identified as one of the most powerful elements of the training. Incorporating ceremony in training is an “example of balance being created in a learning

situation, where colonialism and Indigenous resistance are explored on the one hand and Indigenous culture and cosmology on the other” (Richardson et al., 2017, p. 191). Davis et al. (2016) agree that experiential learning, where non-Indigenous people enter Indigenous spaces to participate in Indigenous practices and teachings, are important learning opportunities. Guerra & Kurtz (2017) similarly emphasize the importance of incorporating experiential learning in cultural safety training and the need to go beyond classroom settings “and involve the Indigenous community in enhancing students’ understanding” (p. 140).

These findings also suggest that participating in a talking circle during this type of training, in which each learner has the opportunity to speak in turn, represents an effective learning experience. Similarly, Richardson et al. (2017) state that, “silence is a valid response and no one is forced to speak. Over time, participants become more comfortable sharing thoughts, feelings and responses to the content” (p. 191).

Facilitating discomfort appears to be an important part of one’s transformational journey and participating in Indigenous pedagogy has been described as “transformational discomfort”. This transformation often begins when non-Indigenous people experience, first-hand, the limits of their knowledge when compared to the cultural and land-based knowledge of Indigenous Elders and Knowledge Holders (Irlbacher-Fox, 2014); when they come to realize that, “I cannot filet a fish; I cannot skin a moose; I cannot read the land; I do not know the cultural rules; I cannot understand the language, I do not know the history of this place” (Irlbacher-Fox, 2014, p. 155). Irlbacher-Fox explains that discomfort becomes a driver of change, where privilege and colonial mindsets becomes more apparent (because they are not useful in this context) and replaced with more appreciation and awareness of Indigenous ways of knowing.

Trained Facilitators

Cultural safety facilitators play an important role in creating safe learning environments, particularly for Indigenous learners. This requires thorough and thoughtful training for facilitators in the areas of non-judgement and respect. While this was not directly identified in the current study, it is a reoccurring theme in the literature. Facilitators must be equipped to provide not only the curriculum, but to engage with a range of their own and others' responses that can emerge within cultural safety training. These competing responsibilities also include empathy for participants' emotions while ensuring productive discussions that occur in a timely manner.

In his studies examining the psychology of racial dialogues in higher education, Sue (2013) reports that students consistently requested that facilitators name and identify the feelings that emerge from challenging content and that racial tensions be addressed directly. Willen (2013) contends that facilitators must acknowledge the vulnerability and risk felt by participants in cultural competency [safety] workshops, especially as participants might feel challenged by their peers. Thus, facilitators “must be prepared to manage it [participant vulnerabilities] in ways that are both pedagogically meaningful and respectful of personal stakes” (Willen, 2013, p. 258). A challenge facing facilitators in the study by Cushman et al. (2015) included balancing the needs of more advanced students, with students less engaged, as well as the discomfort elicited by the content with the responsibility to increase students' knowledge and awareness. As described by Churchill et al. (2017), “individuals who facilitate cultural safety training programs must be trained in delivering the curriculum; supporting decolonizing, anti-racist, reflexive pedagogy; and managing resistance from non-Indigenous – often White – participants” (p. 10). Thackrah and Thompson (2013) also agree that addressing discomfort requires “skilful management” (p. 119). Furthermore, it is important to note that facilitators themselves may be

the victims of backlash, including accusations of “reverse-racism” (Delaney et al., 2018; Richardson et al., 2017).

The cumulative responsibility to manage participant emotions, micro-aggressions, and tensions (including the ability to recognize, name and address them to facilitate learning and prevent harm), as well as meet diverse cultural safety learning needs, indicates the breadth of education, skills, and experience required by facilitators. One of the recommendations presented by Churchill et al. (2017) clearly articulates that trained facilitators must lead and deliver cultural safety training. Taken together, this suggests that facilitators will need the appropriate training and skills in order to deliver cultural safety training. Furthermore, supportive services and self-care identified in the literature for facilitators include counseling (Cushman et al., 2015), team facilitation that includes both Indigenous and non-Indigenous instructors (Thackrah & Thompson, 2013), as well as ongoing professional development and resources and, last but certainly not least, time (Delany et al., 2018).

Identifying Biases

The findings reveal that facilitators can enhance their credibility when they share their own vulnerabilities with learners. Opportunities to share “snapshots” with students, including stories about slipups, ongoing challenges, and breakthrough moments are supported by the literature (Smith, Kashubeck-West, Payton, & Adams, 2017). This can lead to a reduction in participant anxiety, particularly when entering discussions about race and racism. The literature consistently identifies “racial positioning” and the act of identifying one’s biases as an important teaching strategy (Churchill et al., 2017; Durey et al., 2016). This finding also supports research by Sue (2013) that even “racialized” facilitators can have positive effects on students’ willingness to examine their own biases. This suggests that participants are comforted by the

acknowledgement by facilitators, who are perceived as experts in their field, that they possess human flaws and failings. Disclosure by facilitators not only creates a supportive learning environment but also facilitates self-reflections by learners, which helps to address their own biases (Sue, 2013). Self-reflection occurs when learners see facilitators as embodying what is possible and in the case of racism that they begin to understand that “White people can never completely step outside [racism as a system of privilege], but to which they can stand in opposition...” (Smith et al., 2017, p. 662).

Northern Facilitators

The findings suggest a link between a mutually respectful environment and facilitators who are familiar to participants. In the context of the study, this relates to credibility; the longer one lives in the North, the more credibility one garners in the eyes of other Northerners. Participant responses concerning credibility highlight both the complexities of practicing in the NWT and the challenges participants face when confronting difficult content. As an Indigenous person born and raised in the North, I also interpret this finding in the context of commitment. My commitment to the North is connected to the land and my ancestors. While the same cannot be said for non-Indigenous Northerners (whether born in the North or long-term residents), I do believe commitment to the North is felt in their own way as perhaps a shared identity. This shared respect and connection to the North establishes credibility to speak on matters that occur here.

The NWT is a highly transient place, which has resulted in “above-average number of short-term health care providers – often from southern provinces. All of this poses a significant challenge to building and sustaining the capacity to deliver consistent and quality care across the NWT” (Leith, Kirvan, Verma, Lewis, & Robertson, 2012, p. 19). Northern and Indigenous

clinicians who are likely overworked as well as tasked with providing ongoing orientation to new Southern hires may more acutely experience this. These are important contextual factors that organizers may wish to address in their curriculum, tied ultimately to larger issues related to inequities of Indigenous peoples.

Sufficient Time & Ongoing Support

Both time and ongoing support are important training considerations if clinicians expect to learn about and practice cultural safety. For example, ensuring sufficient time is allocated to addressing content, specifically related to power, unearned privilege, bias, and self-reflection, has been reported in these findings and in the literature (Llerena-Quinn, 2013; Ranzijn et al., 2013; Willen, 2013).

Learners require time to process content and work through unsettled feelings that may emerge during cultural safety training. If insufficient time is allocated and participants leave with unresolved feelings, guilt and shame can arise, which can result in avoidance of further training and internalized hatred (Ranzijn et al., 2013, Willen, 2013). Furthermore, Sonn (2008) asserts that addressing racism “may require more than a single semester of reading and engagement. Students will need ongoing guidance, support, and critical self-reflection as part of the process of developing their critical capacities, which are central to working against structures of domination” (p. 164). This suggestion aligns with that of Cushman et al. (2015), who discovered that participants needed structured support following cultural competency (safety training. Learners will also need more than one session within a two-day workshop to adequately learn about, become aware, and actively address personal biases and privileges. Indeed, Cushman et al. (2015) acknowledged that additional follow-up training was required to their one-day workshop.

The participants of the current study provided a number of suggestions for post-training supports to enhance their capacity, including: annual training, lunch and learns, the formation of a committee dedicated to cultural safety training, community mentors for practitioners in smaller communities. Making time on the agenda for participants to discuss next steps and build stronger connections between clinicians who live in the smaller regional centres and communities can also facilitate support.

Chapter 5: Conclusion, Implications and Recommendations

In this final chapter, I provide a brief overview of the study's purpose and methodological approach, followed by its implications and opportunities for future research. These are discussed in relation to relevant research literature as well as training, including Indigenous pedagogy, learning, context and policy. Limitations of the pilot intervention and the study design are also noted. Recommendations are then offered for the Department of Health and Social Services (DHSS), followed by reflections and closing thoughts.

In order to realize cultural safety training, where Indigenous peoples feel secure and respected when interacting with health care providers, the training itself must be current, helpful and effective. This study had two main aims: to assess the experiences and perceptions of clinicians who participated in a pilot cultural safety intervention; and to make recommendations about the pilot intervention in terms of design, content, and delivery. Although this research serves a practical purpose, in that it will be used to inform future cultural safety training efforts by the DHSS, it also addresses an existing gap in literature, which reports on the implementation of such training (Churchill et al., 2017; Richardson et al., 2017; Wabano Centre for Aboriginal Health, 2014; Thackrah & Thackrah, 2013; Kirmayer, 2012; Gibbs, 2005).

This study provides contextual details related to clinician learning and engagement of cultural safety training in the NWT that may be insightful to program developers in other jurisdictions. I incorporated Indigenous and process evaluation principles to provide a framework to undertake the research project. I used a decolonizing lens, inherent within Indigenous methodologies, to make meaning of participant responses within the context of power dynamics

at individual and distal levels. The process evaluation reflected the goal of the study to examine how clinicians responded, perceived and experienced the process of participating in an intervention and guided most aspects of the research design, including the qualitative approach to data collection. Process evaluation can reveal valuable information about which aspects of a training program either facilitate or hinder learning. This is particularly important as cultural safety content is both challenging to learn and teach (Churchill, 2017; Ranzijn & McConnochie, 2013; Gibbs, 2005).

Implications of Findings and Future Research

The findings of this research will inform the DHSS, particularly policy makers, program developers and evaluators, about how to enhance clinician learning and engagement as the NWT training model is further refined in preparation for widespread implementation. The significance of this training for clinicians practicing in the NWT includes a number of elements. These include: an increase in knowledge and awareness about Indigenous colonial history, specifically within an NWT context; other social determinants of Indigenous peoples' health that includes hearing directly from NWT Indigenous facilitators about their residential school experiences; exposure to Indigenous pedagogy; learning about power, privilege, and settler colonialism; and racism and bias in health care policies and practices. Finally, clinicians learned about the importance of self-reflection; to think critically about distal determinants and how these processes manifest and are perpetuated by mainstream institutions, personal biases, assumptions, and unearned power and privilege. Together, this curriculum informed by the findings from this study has the potential to transform relationships between Indigenous peoples and clinicians that are trusting, respectful, and meaningful. On a broader level, the implications of cultural safety are far reaching and should be viewed within the context of "reconciliation and relationship-

building efforts, as Indigenous and non-Indigenous individuals, communities, and governments seek to find a way forward together” (Greenwood, Lindsay, King, & Loewen, 2017, p. 187).

Related to Training

Indigenous Pedagogy. Greenwood et al. (2017) argue for the transformation of health care systems through embracing two-eyed seeing, an approach for creating ethical space for Indigenous and western knowledge systems to work together. Yet, this will require making space to privilege and honour Indigenous voices, values, and concepts within the health care system. Arguably, the design and delivery of cultural safety training should be approached in the same way. This was echoed by participants in this study. While many aspects of the pilot intervention were either grounded in Indigenous approaches or facilitated by Indigenous peoples, the pilot itself did not emerge from an Indigenous epistemology, as a non-Indigenous consultant was responsible for its design. The inclusion of Indigenous peoples from design conception to delivery is necessary. This reflects the motto “Nothing about us without us”, which means that nothing should be created about or for Indigenous peoples without their meaningful involvement (Adams, 2017, p. 8). Moreover, when organizations adopt the true meaning of cultural safety, it is an acknowledgement that drastic changes are required. This change can only come from true Indigenous engagement. Best articulated by Greenwood et al. (2017), “For far too long, Western thought worlds have dominated, repressed, and sought to eliminate Indigenous ones; thus, it is the former that will have to learn from the latter how to enter into respectful relationships” (p. 187).

The findings suggest that non-Indigenous clinicians in the NWT are ready for change. They are hungry for knowledge about Indigenous history, to understand medicines and participate in sacred practices, and desire training rooted in Indigenous epistemology. This

research demonstrates that Indigenous pedagogy, through experiential activities, also facilitates healing and learning, and contributes to a safe environment for participants. This is absent from the recently released document outlining wise practices for Indigenous-specific cultural safety training programs within a Canadian context (Churchill et al., 2017). Rather, they argue that training be grounded in decolonizing and anti-racist pedagogy. I would add that training should also be rooted in Indigenous epistemology; thus, reflecting a two-eyed seeing approach. Indigenous epistemology makes room for Indigenous voices and disrupts learners' worldviews, which is critical to learning.

The need for experienced and trained facilitators was identified in this study. However, it is unclear from the literature what type of training or experience facilitators require in delivering cultural safety training. For example, the facilitators responsible for this study's pilot intervention were highly educated; one facilitator has a PhD, one is an MD, and the two Indigenous facilitators are well-known Knowledge Holders. Further research could assess the qualities, knowledge, experience, and training of successful cultural safety facilitators.

Learning. Despite undertaking a study that focused primarily on participant experiences of attending a pilot training program, it should not come as a surprise that participants actually took away valuable long-term learnings. Interviews were conducted approximately 5-9 months following the intervention (also a limitation), indicating that participants had retained learning. Participant learnings were consistent with some of the expected cultural safety learning outcomes as they reported improved knowledge in the areas of Indigenous history and colonization, increased awareness and empathy, and shifts in colonial perspectives. This suggests the pilot intervention may be an effective model for facilitating learning and behavioural changes.

Related to Context and Policy. These findings further suggest that cultural safety training alone is unlikely to facilitate systemic change across an organization. Institutional change must accompany training efforts in order for clinicians and staff to provide successfully culturally safe care to Indigenous patients and clients. This can be achieved by embedding cultural safety into policies, which requires an examination of how the institution itself creates barriers in policies, procedures, and funding allocations (e.g., smudging in facilities, support for Northern Indigenous physicians, hospital visiting hours, and allocation of time to establish relationships during clinic visits). While “training may be valuable, the organizational culture within health care institutions carries a strong weight of the past, normalizing colonial practices that reinforce the inferiority of Indigenous peoples and practices” (Wyle & McConkey, 2018, p. 8). Further research could examine cases where organizations are addressing systemic issues while delivering cultural safety training, and whether these intersecting activities do, in fact, result in improved care for Indigenous peoples.

Related to Research Literature. Although there is no shortage of literature pertaining to the theory and value of cultural safety as a concept, less is available about its application to training. There are only a handful of publications specific to cultural safety training implementation (Churchill et al., 2017; Richardson et al., 2017; Wabano Centre for Aboriginal Health, 2014; Thackrah & Thackrah, 2013; Kirmayer, 2012; Gibbs, 2005). This has led to a reliance on literature focusing on specific aspects of cultural competency training such as ethnicity, race, racism, and privilege, which address inequities of both Indigenous and racialized people in Canada, United States, and Australia (Jacob et al., 2016; Richardson et al., 2017; Kowal et al., 2013; Sue, 2013; Watt et al., 2009; Sonn, 2008).

As there is a dearth of Canadian evaluative research and literature available on the development and implementation of cultural safety training, these findings help to bridge that gap from an NWT context; specifically as it applies to the challenges and conditions necessary to enhance cultural safety learning. At the same time, to my knowledge, no comparable academic studies or evaluations are publicly available that details an NWT specific cultural safety training that is held on the land and inclusive of Indigenous pedagogies. This underscores the uniqueness of this study.

Ongoing research and evaluation examining both the processes and outcomes of cultural safety training are important for improvement purposes but also for demonstrating effectiveness in terms of Indigenous satisfaction and improved health outcomes. The effectiveness of cultural safety training in terms of health outcomes among Indigenous peoples also represents a gap in the literature (Durey, 2010). An evaluation framework to measure effectiveness in terms of participant learning and application to practice, patient and client satisfaction, and health outcomes should accompany the implementation of formal training. As Indigenous peoples are the ones to determine whether their care is culturally safe, research examining NWT Indigenous residents' expectations of health care interactions could inform an evaluation framework. In addition, research and evaluation could assess the optimal time required for training approaches to shift behaviours and practice as well as format, venue, duration, and sequencing.

In addition to the need for summative and formative evaluative research, there is a need for detailed information about whether training programs are oriented towards cultural safety or something else (Churchill et al., 2017). For example, training may be incorrectly labeled as 'cultural safety' when its focus is cultural awareness. As Churchill et al., (2017) point out, "Gaps

in reporting can also make it difficult to reach conclusions about what types of cultural safety training programs work best and why” (p. 9).

Limitations

Related to Pilot Intervention

Clinicians volunteered to participate in the pilot intervention and the research project. This implies that these individuals were already interested in learning about and practicing cultural safety. Moreover, the pilot workshop was promoted as a “think tank”, which might have resulted in the participation of individuals who perceive themselves as experts in the field. In either case, the participants may not be representative of the NWT clinician population.

Related to Study Design

As I did not collect participant demographic information, I had to rely on participants self-reports of Indigeneity. The only participant who self-identified as Indigenous also commented on the lack of Indigenous participants at the pilot workshop. Indigenous participants can provide valuable insights about cultural safety training, which might not be identified by non-Indigenous participants.

I did not receive ethical approval from the University of Victoria and the Aurora Research Institute until February 16, 2015 and February 19, 2015 respectively. Therefore, data collection began in March and lasted until July 2015. This meant that five-to-nine months had elapsed since the pilot intervention, which might have affected participants’ recall of their experiences.

This research process has been a long learning journey. In retrospect, I could have incorporated Indigenous methodologies in ways that are more meaningful. For example, allocating time for introductions not only helps to create trust with participants but it also

facilitates relationships, which is an integral Indigenous value. I could have presented gifts to acknowledge and give thanks to participants who were willing to share their experiences with me. Although this research has ended, these are practices that I have come to adopt as part of my everyday work practices and will incorporate into any future research projects I pursue.

My status as a local Indigenous woman exploring the topic of cultural safety may have led participants to respond in a way that reflects social desirability bias and to prevent portraying themselves as racist. For similar reasons, my status as a DHSS employee may have been a limitation as the participants are employed within the health sector in which I am indirectly connected as well.

Recommendations for DHSS

Design

1. Frame training as part of a wider effort towards reconciliation and health equity, where the goal of cultural safety is the creation or transformation and maintenance of mutually respectful relationships between Indigenous and non-Indigenous peoples at societal and institutional levels. This will involve developing and building in curriculum about the Royal Commission on Aboriginal Peoples and the Truth and Reconciliation Commission.
2. DHSS program developers should connect with Aurora College to discuss possible collaboration opportunities, as an article by Moffitt (2016) revealed that the Aurora College Nursing Program in the NWT has incorporated many aspects of cultural safety into their nursing curriculum.
3. Ensure curriculum design and delivery reflects a two-eyed seeing approach where both Indigenous and western concepts are equally valued and incorporated. This means that training be grounded in decolonized, anti-racist, and Indigenous pedagogies. Indigenous

staff and program developers must take a leading role in cultural safety design and development.

4. Indigenous staff and program developers must have integral roles, if not lead, implementation and evaluation of cultural safety interventions.
5. Training should not be limited to clinicians but offered broadly to all staff employed at the Northwest Territories Health and Social Services Authority, the Hay River Health and Social Services Authority, the Tlicho Health and Social Services Authority, and the DHSS. Indigenous patients and clients interact with the entire health care system, from administrative assistants to program staff at the DHSS. Policy makers and senior management staff should be among the first to participate upon roll-out. Healthy public policy builds on a deep understanding and appreciation of Canada's colonial history and its role shaping current Indigenous health inequities (Richmond & Cook, 2016; TRC, 2015b).
6. If training is mandatory, ensure Indigenous participation is optional.
7. Appropriate emotional and spiritual supports must be in place for Indigenous staff choosing to participate.
8. Provide clear learning objectives to prevent misconceptions that cultural safety involves only learning about Indigenous cultures and practices. Set expectations that discomfort is a normal and productive reaction to content.
9. Develop an evaluation framework in tandem with training development. Ongoing process and outcome evaluation is critical for continuous improvement efforts and for determining the achievement of short-term and long-term objectives.

Content

1. Dominant discourses of colour-blindness and rejection of settler colonialism were emergent themes within the findings. Based on this, future trainings should embed activities that help participants unpack dominant health care discourses, paying special attention to how these discourses mask and perpetuate discrimination. Tang & Browne (2008) maintain that “work of recognizing and mitigating racialization in health care cannot be accomplished by avoiding the difficult discussion of ‘race’ or by denying the existence of racism and other forms of inequities” (p. 124).
2. Cultural safety training should include content, activities, and discussion materials that reflect all participant professions, to foster learning and application of content and skills in practice.

Delivery

1. Where possible, trainers should be Indigenous Northerners and/or non-Indigenous Northerners as findings indicate this preference.
2. Ensure facilitators are properly trained and prepared to deliver cultural safety training to both Indigenous and non-Indigenous learners. The ability to create safe learning spaces is critical. Ongoing opportunities to inform program design for continuous improvements and having necessary trainer emotional and spiritual supports must be prioritized to prevent facilitator burnout. This is particularly important for Indigenous facilitators.

Reflections and Closing Thoughts – Mahsi Cho

In preparing to write this concluding segment, I asked for guidance from the Creator and my grandparents so that I could end this thesis in a good way. I am told – to speak from my heart. Training in cultural safety is more than simply a program; if executed properly, it has the power to transform and inspire the workforce to be in relationship with Indigenous patients and

clients. Reaching learners by tapping into their minds, emotions, and spirit, while showing the same kind of respect cultural safety strives to achieve, is an Indigenous and Dene way. Health care does not operate in a bubble; staff are part of broader Canadian society and are in a position to influence widespread transformation of longstanding stereotypes about Indigenous peoples and the need to live together respectfully. Moreover, the Truth and Reconciliation Commission Calls to Action remind us that cultural competency [safety] training is not just the responsibility of the health sector, but all public servants, including the private sector.

Finally, I would be remiss if I did not highlight the sheer importance and weight institutional policies carry in facilitating this transformative process. If training and corresponding culturally safe behaviours is not supported at the institutional level, it will be difficult for these kinds of projects to have the intended effects. For these reasons, I truly hope this pilot program will succeed. In my role as a DHSS employee, I am optimistic about the path we are embarking upon. The DHSS is about to release an action plan dedicated to cultural safety, the development of which I was fortunate enough to play a role. In this action plan, a commitment is made to develop cultural safety training for staff. I feel very privileged to be in a position where I can directly apply my years of learning and understanding of cultural safety to an NWT context, on my homeland and for my people. Mahsi.

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Appendix A Recruitment Email

Invitation to Participate: Process Evaluation for “Cultural Capabilities Think Tank”

You are being contacted because you recently participated in the pilot intervention, “Cultural Capabilities Think Tank” from October 22-23, 2014 at Aurora Village Lodge. In an effort to ensure that the process and activities of the pilot workshop were relevant and useful to your learning needs as health professionals in the Northwest Territories, the Department of Health and Social Services is conducting a process evaluation before full implementation of the intervention.

Undertaking the process evaluation is Ms. Karen Hall, a Master’s student at the University of Victoria and a Senior Policy Advisor in Aboriginal Health in the Aboriginal Health and Community Wellness division of the Department of Health and Social Services (DHSS-AHCW). Ms. Hall was offered the opportunity by the DHSS-AHCW to undertake a process evaluation of the pilot intervention for her Master’s thesis. Therefore, the client for Ms. Hall’s research is the DHSS-AHCW. Please note, the client will not be made aware of who decides to participate in the study and will only have access to analyzed data.

What does the process evaluation involve?

You are asked to participate in a one-on-one interview with Ms. Hall that will take approximately 1-2 hours. You will be asked questions about the pilot intervention’s design, content, and delivery. Depending on where you reside, the interview will take place in person or by telephone. Please note that participation in the interview is completely voluntary and declining to participate or withdrawing from the study at any point will have no effect on your employment.

This study will also analyze the anonymous questionnaires you completed during the “Cultural Capabilities Think Tank”.

How to participate?

If you would like further information and/or would like to participate in the “Cultural Capabilities Think Tank” process evaluation, **please do not reply to this email**. Rather, please contact Ms. Hall directly:

Karen Hall
doxhae@uvic.ca or Karen_blondinhall@gov.nt.ca
867-447-3705 (c) or 867-8916 (w)

Appendix B Interview Guide

Thank you for agreeing to participate in this interview. As you know, I am a evaluating the “Cultural Capabilities Think Tank” pilot intervention for my Master’s thesis. The following questions will be asked to hear your views on the process and activities of the pilot intervention and their relevancy and usefulness to your learning needs as health professionals in the Northwest Territories. The interview will take approximately 1-2 hours of your time.

1. In what ways were the learning needs of your profession met during this workshop?

Probe: what worked well?

- a. In what ways were the learning needs of your profession not met?

Probe: what needs improvement?

2. In what ways were you made to feel respected during the workshop?

Probe: how did you feel respected as a participant? Were there any particular experiences?

- a. In what ways were you not made to feel respected during this workshop?

Probe: how could it have been a better experience?

3. In what ways was the workshop well organized?

- a. In what ways was the workshop not well organized?

Probe:

- Pace of workshop sessions
- Sequence of content and activities
- Length of sessions

4. In what ways was the content relevant to your profession?

Probe: how was the content useful?

- a. In what ways was the content not relevant to your profession?

Probe: how was the content not useful? What content would be more useful to your health profession?

5. In what ways were the facilitators knowledgeable in the subject matter?

Probe: what makes you think the facilitators were knowledgeable in the subject matter?

- a. In what ways were the facilitators not knowledgeable in the subject matter?

Probe: what needs improvements in regards to the facilitators and the subject matter?

6. In what ways were the activities in the workshop useful?

Probe: what activities worked well?

- a. In what ways were the activities in the workshop not useful?

Probe: how can the activities be improved to make them useful?

7. In what ways were the resources provided in the workshop useful?

Probe: how were the resources relevant?

- a. In what ways were the resources provided in the workshop not useful?

Probe: what resources would be relevant to you?

8. In what ways did the space of the workshop meet your needs?

Probe: how did the location and setting meet your needs?

- a. In what ways did the space of the workshop not meet your needs?

Probe: what suggestions do you have for the workshop space in the future?

9. Is there anything else you would like to say about the workshop?

**Appendix C
Information Sheet
Telephone Interviews**

**Developing a Cultural Safety Intervention for Clinicians: Process
Evaluation of a Pilot Study in the Northwest Territories**

Researcher:

Karen Hall, MA student, Faculty of Human Social Development, University of Victoria
Phone: 867-447-3705(c); 867-920-8916(w); doxhae@uvic.ca or
Karen_blondinhall@gov.nt.ca

Supervisors:

Michael Prince, PhD, Professor, Human and Social Development, University of Victoria

Charlotte Reading, PhD, Professor, Human and Social Development, University of Victoria

What is this study for?

This study involves a process evaluation of the pilot intervention, “Cultural Capabilities Think Tank” that took place at Aurora Village Lodge from October 22-23, 2014. In an effort to ensure that the process and activities of the pilot intervention were relevant and useful to the learning needs of health professionals in the Northwest Territories, Ms. Hall will be undertaking a process evaluation before full implementation of the intervention.

The research objectives for Ms. Hall’s study are: (1) to assess the process of the pilot intervention in the Northwest Territories and (2) to make recommendations to the intervention’s design, content, and delivery based on pilot findings and analysis.

Who is running it?

Ms. Karen Hall is a Senior Policy Advisor in Aboriginal Health in the Aboriginal Health and Community Wellness division of the Department of Health and Social Services (DHSS-AHCW) and a Master’s student in the Faculty of Human and Social Development at the University of Victoria. Ms. Hall was offered the opportunity by the DHSS-AHCW to undertake a process evaluation of the pilot intervention for her Master’s thesis. Therefore, the client for Ms. Hall’s research is the DHSS-AHCW. Please note, the client will not be made aware of who decides to participate in the study and will only have access to analyzed data.

Ms. Hall is a locally born Dene First Nations who has previous qualitative research experience as a research assistant for several research projects, as well as her

undergraduate research project and as a Jane Glassco Arctic Fellow.

Why is your participation important?

As this intervention is designed to provide clinicians with the awareness, knowledge and skills required to create culturally safe environments, it is critical that the design, content, and process is of the highest quality. Consequently, your input as a clinician is critical in this process evaluation.

Who can take part in the study?

If you participated in the “Cultural Capabilities Think Tank” from October 22-23, 2014 at Aurora Village Lodge, you are invited to participate.

What do the participants do?

If you consent to voluntarily participate in this research, Ms. Hall is asking your participation in the following ways:

- The interview will take place over the telephone. To avoid any lost distance charges associated with the telephone call, Ms. Hall will call you, unless otherwise stated.
- At the beginning of the interview, Ms. Hall will review the consent form with you over the telephone and answer any questions you may have before asking you to provide verbal consent. Verbal consent will be audio recorded and documented in a verbal consent log.
- The interview will take approximately 1-2 hours of your time.

When you attended the “Cultural Capabilities Think Tank”, you completed a series of anonymous questionnaires about the pilot intervention. These anonymous questionnaires will also be used in the analysis for Ms. Hall’s study.

What about confidentiality and privacy?

You will be given the option to have your telephone interview during work hours or after work hours. If you choose to participate during work hours and need to seek permission from your employer, this is a limit to your confidentiality.

This study is drawing from a small pool of participants which is a limit to your confidentiality. This is because (1) you are a clinician practicing in a small rural community or regional centre and (2) you attended the “Cultural Capabilities Think Tank”. These contexts make it possible for those not part of the research project to identify individual participants.

The interviews will be audio recorded and later transcribed. Ms. Hall will remove all names and potential identifying information from those transcripts before data analysis begins.

Your consent will be audio recorded and documented on a verbal consent log, which will be stored in a locked filing cabinet in a storage facility only accessible by Ms. Hall in Yellowknife. The electronic data (including transcripts) will be stored on Ms. Hall's personal computer that is password-protected. The verbal consent log will be kept separately from the interview materials in a sealed envelope in the locked filing cabinet. All research materials will be destroyed after five years after analysis is complete. Paper copies will be securely shredded and electronic material will be permanently deleted.

Ms. Hall's Master's thesis and summary report for the DHSS will be written in such a way that the identity of persons who participated in the pilot intervention cannot be identified directly or indirectly. The DHSS will not be made aware of who decides to participate in the study and will only have access to analyzed data.

What are the results going to be used for?

The findings from the evaluation of the pilot intervention will be used as Ms. Hall's Master's thesis project. Ms. Hall's thesis, based on the pilot intervention evaluation results, will also inform the DHSS of how the pilot can be refined for the future intervention in the form of a report. The goal is to develop a sustainable intervention for clinicians to provide Indigenous peoples in the NWT a culturally secure health care environment.

The results will also be presented at scholarly meetings and the thesis will be made publically available through the University of Victoria "UVicSpace". An executive summary of Ms. Hall's thesis will be available if you would like a copy of the results.

Is participation voluntary?

Participation in an interview is completely voluntary and should you decline this invitation to participate, it will not impact your employment. If you choose to withdraw from the study your data will not be used in the analysis and will be destroyed unless you indicate otherwise.

You have the right to withdraw from the pilot intervention and Ms. Hall's study at any point without repercussion to your employment or travel arrangements. If you choose to withdraw, it will not be possible to remove your contributions to the study as your questionnaires will be submitted anonymously.

Inconvenience

Participation in this study may cause some inconvenience to you, including finding time in your schedule either during work hours or after work hours to participate in the

interview.

Are there any risks and benefits?

There are no known or anticipated risks to you by participating in this research.

The possible benefits of this study include the potential for Aboriginal patients to access health and social services on a more regular basis and in an environment that is culturally secure. For clinicians, like yourself, a sense of satisfaction and confidence that proper care is being provided and hopefully better received to a population with high health disparities.

Compensation and reimbursement

You will not be compensated for your participation in this research project and you should not incur additional expenses.

Contacts

If you have additional questions or a desire to speak further about the research, please contact the researcher, Ms. Karen Hall, as noted above.

If you would like to verify the ethical approval of this study, or raise any concerns about any aspect of your participation in this study, you may contact the Human Research Ethics Office at University of Victoria (250-472-4545 or by email at ethics@uvic.ca).

**Appendix D
Information Sheet
In-Person Interviews**

**Developing a Cultural Safety Intervention for Clinicians: Process
Evaluation of a Pilot Study in the Northwest Territories**

Researcher:

Karen Hall, MA student, Faculty of Human Social Development, University of Victoria
Phone: 867-447-3705 (c); 867-920-8916 (w); doxhae@uvic.ca or
Karen_blondinhall@gov.nt.ca

Supervisors:

Michael Prince, PhD, Professor, Human and Social Development, University of Victoria

Charlotte Reading, PhD, Professor, Human and Social Development, University of Victoria

What is this study for?

This study involves a process evaluation of the pilot intervention, “Cultural Capabilities Think Tank” that took place at Aurora Village Lodge from October 22-23, 2014. In an effort to ensure that the process and activities of the pilot intervention were relevant and useful to the learning needs of health professionals in the Northwest Territories, Ms. Hall will be undertaking a process evaluation before full implementation of the intervention. The client of this research is the Government of the Northwest Territories’ Department of Health and Social Services.

The research objectives for Ms. Hall’s study are: (1) to assess the process of the pilot intervention in the Northwest Territories and (2) to make recommendations to the intervention’s design, content, and delivery based on pilot findings and analysis.

Who is running it?

Ms. Karen Hall is a Senior Policy Advisor in Aboriginal Health in the Aboriginal Health and Community Wellness division of the Department of Health and Social Services (DHSS-AHCW) and a Master’s student in the Faculty of Human and Social Development at the University of Victoria. Ms. Hall was offered the opportunity by the DHSS-AHCW to undertake a process evaluation of the pilot intervention for her Master’s thesis. Therefore, the client for Ms. Hall’s research is the DHSS-AHCW. Please note, the client will not be made aware of who decides to participate in the study and will only have access to analyzed data.

Ms. Hall is a locally born Dene First Nations who has previous qualitative research

experience as a research assistant for several research projects, as well as her undergraduate research project and as a Jane Glassco Arctic Fellow.

Why is your participation important?

As this intervention is designed to provide clinicians with the awareness, knowledge and skills required to create culturally safe environments, it is critical that the design, content, and process is of the highest quality. Consequently, your input as a clinician is critical in this process evaluation.

Who can take part in the study?

If you participated in the “Cultural Capabilities Think Tank” from October 22-23, 2014 at Aurora Village Lodge, you are invited to participate.

What do the participants do?

If you consent to voluntarily participate in this research, Ms. Hall is asking your participation in the following ways:

- The interview will take place in person, at a location that you identify to be convenient to you.
- At the beginning of the interview, Ms. Hall will review the consent form with you and answer any questions before asking you to sign the consent form.
- The interview will take approximately 1-2 hours of your time.

When you attended the “Cultural Capabilities Think Tank”, you completed a series of anonymous questionnaires about the pilot intervention. These anonymous questionnaires will also be used in the analysis for Ms. Hall’s study.

What about confidentiality and privacy?

You will be given the option to have your interview during work hours or after work hours. If you choose to participate during work hours and need to seek permission from your employer, this is a limit to your confidentiality.

This study is drawing from a small pool of participants which is a limit to your confidentiality. This is because (1) you are a clinician practicing in a small rural community or regional centre and (2) you attended the “Cultural Capabilities Think Tank”. These contexts make it possible for those not part of the research project to identify individual participants.

The one-on-one interviews will be audio recorded and later transcribed. Ms. Hall will remove all names and potential identifying information from those transcripts before data analysis begins.

Consent forms collected during the evaluation will be stored in a locked filing cabinet in a storage facility only accessible by Ms. Hall in Yellowknife. The electronic data (including transcripts) will be stored on Ms. Hall's personal computer that is password-protected. Consent forms will be kept separately from the interview materials in a sealed envelope in the locked filing cabinet. All research materials will be destroyed after five years after analysis is complete. Paper copies will be securely shredded and electronic material will be permanently deleted.

Ms. Hall's Master's thesis and summary report for the DHSS will be written in such a way that the identity of persons who participated in the process evaluation cannot be identified directly or indirectly. The DHSS will not be made aware of who decides to participate in the study and will only have access to analyzed data.

What are the results going to be used for?

The findings from the evaluation of the pilot intervention will be used as Ms. Hall's Master's thesis project. Ms. Hall's thesis, based on the pilot intervention evaluation results, will also inform the DHSS of how the pilot can be refined for the future intervention in the form of a report. The goal is to develop a sustainable intervention for clinicians to provide Indigenous peoples in the NWT a culturally secure health care environment.

The results will also be presented at scholarly meetings and the thesis will be made publicly available through the University of Victoria "UVicSpace". An executive summary of Ms. Hall's thesis will be available if you would like a copy of the results.

Is participation voluntary?

Participation in an interview is completely voluntary and should you decline this invitation to participate or withdraw from the study at any point, there will be no consequences to you or your employment. If you choose to withdraw from the study your data will not be used in the analysis and will be destroyed unless you indicate otherwise.

Inconvenience

Participation in this study may cause some inconvenience to you, including finding time in your schedule either during work hours or after work hours to participate in the interview.

Are there any risks and benefits?

There are no known or anticipated risks to you by participating in this research. The possible benefits of this study include the potential for Aboriginal patients to access health and social services on a more regular basis and in an environment that is culturally secure. For clinicians, like yourself, a sense of satisfaction and confidence that proper care is being provided and hopefully better received to a population with high health disparities.

Compensation and reimbursement

You will not be compensated for your participation in this research project and you should not incur additional expenses.

Contacts

If you have additional questions or a desire to speak further about the research, please contact the researcher, Ms. Karen Hall, as noted above.

If you would like to verify the ethical approval of this study, or raise any concerns about any aspect of your participation in this study, you may contact the Human Research Ethics Office at University of Victoria (250-472-4545 or by email at ethics@uvic.ca).

Appendix E

Eligibility Script

Before you can join the study, I need to determine if you are eligible to be a research participant by asking the following question: “Did you attend the ‘Cultural Capabilities Think Tank’ as a clinician from October 22-23, 2014 at Aurora Village Lodge?”

If individual indicates no, thank the individual for their time, explain why they are not eligible (this is a process evaluation of an intervention therefore participants must have attended the intervention) and end conversation.

If individual indicates yes, continue:

You are eligible to participate in this study. It is important for you to know that participating in this study is your decision and completely voluntary. Whether or not you choose to participate in this study will have no effect on your employment.

Do you have any more questions about the research that I can answer now?

Appendix F
Consent Form

**Developing a Cultural Safety Intervention for Clinicians: Process
Evaluation of a Pilot Study in the Northwest Territories
In-person Interviews**

Consent Form

I have read the attached information sheet and understand the nature of the study as described in the information sheet. I understand my participation in the study entitled **Developing a Cultural Safety Intervention for Clinicians: Process Evaluation of a Pilot Study in the Northwest Territories** is entirely voluntary and I may refuse to participate or withdraw from the study at any time. I may decline to answer any particular questions that I prefer not to answer. I fully understand my rights as a participant in this study and the limitations to my confidentiality. I was given a copy of this consent form for my record.

I agree that my in-person interview will be audio recorded.

(Print Name)

(Signature)

(Date)

(Location)

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix G Verbal Consent Form

Developing a Cultural Safety Intervention for Clinicians: Process Evaluation of a Pilot Study in the Northwest Territories

Introduction:

Hello, my name is Karen Hall. I am conducting interviews for a process evaluation of the pilot intervention, “Cultural Capabilities Think Thank” that you recently participated in. I am conducting interviews as part of my Master’s research at the University of Victoria’s Faculty of Human and Social Development. I am working under the direction of Dr. Michael Prince and Dr. Charlotte Reading who are also with the Faculty of Human and Social Development at the University of Victoria. In addition, I work as a Senior Policy Advisor in Aboriginal Health in the Aboriginal Health and Community Wellness division at the Department of Health and Social Services (DHSS-AHCW) and was offered the opportunity by the DHSS-AHCW to undertake a process evaluation of the pilot intervention for her Master’s thesis. Therefore, the client for Ms. Hall’s research is the DHSS-AHCW. Please note, the client will not be made aware of who decides to participate in the study and will only have access to analyzed data.

What is this study for?

In an effort to ensure that the process and activities of the pilot intervention were relevant and useful to your learning needs as a health professional in the Northwest Territories, I will be undertaking a process evaluation before full implementation of the intervention.

The research objectives for this study are: (1) to assess the process of the pilot intervention in the Northwest Territories and (2) to make recommendations to the intervention’s design, content, and delivery based on pilot findings and analysis.

Why is your participation important?

As this intervention is designed to provide clinicians with the awareness, knowledge and skills required to create culturally safe environments, it is critical that the design, content, and process is of the highest quality. Consequently, your input as a clinician is critical in this process evaluation.

Who can take part in the study?

If you participated in the “Cultural Capabilities Think Tank” from October 22-23, 2014 at Aurora Village Lodge, you are invited to participate.

What do the participants do?

If you consent to voluntarily participate in this research, I am inviting you to do a one-on-one interview that will take place over the telephone. To avoid any lost distance charges associated with the telephone call, I will call you, unless otherwise stated. The interview will take approximately 1-2 hours of your time.

Your consent will be audio recorded and documented on a verbal consent log.

When you attended the “Cultural Capabilities Think Tank”, you completed a series of anonymous questionnaires about the pilot intervention. These anonymous questionnaires will also be used in the analysis for Ms. Hall’s study.

What about confidentiality and privacy?

You will be given the option to have your telephone interview during work hours or after work hours. If you choose to participate during work hours and need to seek permission from your employer, this is a limit to your confidentiality.

This study is drawing from a small pool of participants which is a limit to your confidentiality. This is because (1) you are a clinician practicing in a small rural community or regional centre and (2) you attended the “Cultural Capabilities Think Tank”. These contexts make it possible for those not part of the research project to identify individual participants.

The telephone interviews will be audio recorded and later transcribed. I will remove all names and potential identifying information from those transcripts before data analysis begins.

The verbal consent log will be stored in a locked filing cabinet in a storage facility only accessible by myself in Yellowknife. The electronic data (including transcripts) will be stored on my personal computer that is password-protected. The consent log will be kept separately from the interview materials in a sealed envelope in the locked filing cabinet. All research materials will be destroyed after five years after analysis is complete. Paper copies will be securely shredded and electronic material will be permanently deleted.

My Master’s thesis and summary report for the DHSS will be written in such a way that the identity of persons who participated in the process evaluation cannot be identified directly or indirectly. The DHSS will not be made aware of who decides to participate in the study and will only have access to analyzed data.

What are the results going to be used for?

The findings from the evaluation of the pilot intervention will be used as my Master’s thesis project. My thesis, based on the pilot intervention evaluation results, will also inform the DHSS of how the pilot can be refined for the future intervention in the form of a report. The goal is to develop a sustainable intervention for clinicians to provide

Indigenous peoples in the NWT a culturally secure health care environment.

The results will also be presented at scholarly meetings and the thesis will be made publically available through the University of Victoria “UVicSpace”. An executive summary of Ms. Hall’s thesis will be available if you would like a copy of the results.

Is participation voluntary?

Participation in an interview is completely voluntary and should you decline this invitation to participate or withdraw from the study at any point, there will be no consequences to you or your employment. If you choose to withdraw from the study your data will not be used in the analysis and will be destroyed unless you indicate otherwise.

Inconvenience

Participation in this study may cause some inconvenience to you, including finding time in your schedule either during work hours or after work hours to participate in the interview.

Are there any risks and benefits?

There are no known or anticipated risks to you by participating in this research.

The possible benefits of this study include the potential for Aboriginal patients to access health and social services on a more regular basis and in an environment that is culturally secure. For clinicians, like yourself, a sense of satisfaction and confidence that proper care is being provided and hopefully better received to a population with high health disparities.

Compensation and reimbursement

You will not be compensated for your participation in this research project and you should not incur additional expenses.

Contacts

If you have further questions or a desire to speak further about this research, you can call me on my cell (867-447-3705) or work phone (867-920-8916) or by email doxhae@uvic.ca or Karen_blonдинhall@gov.nt.ca

If you would like to verify the ethical approval of this study, or raise any concerns about any aspect of your participation in this study, you may contact the Human Research Ethics Office at University of Victoria (250-472-4545) or by email at ethics@uvic.ca

Consent Statement

Researcher script:

Do you have any additional questions about the research study?

Do you give your consent to the following:

The researcher has read the information sheet to me and I understand the nature of the study as described in the information sheet. I understand my participation in the study entitled **Developing a Cultural Safety Intervention for Clinicians: A Pilot Study** is entirely voluntary and I may refuse to participate or withdraw from the study at any time. I may decline to answer any particular questions that I prefer not to answer. I fully understand my rights as a participant in this study and the limitations to my confidentiality. I was emailed or mailed a copy of this consent form for my record.

I agree that my one-on-one interview will be audio recorded.

If yes, start the interview.

If no, thank the participant for their time.

Appendix H
Verbal Consent Log

Recording Verbal Consent

Participant's Name	Date

Appendix I Ethics Certificate



Human Research Ethics Board
Office of Research Services
Administrative Services Building
PO Box 1700 STN CSC
Victoria British Columbia V8W 2Y2 Canada
Tel 250-472-4545, Fax 250-721-8960
ethics@uvic.ca www.research.uvic.ca

Certificate of Approval

PRINCIPAL INVESTIGATOR: Karen Hall UVic STATUS: Master's Student UVic DEPARTMENT: HSD SUPERVISOR: Dr. Michael Prince; Dr. Charlotte Reading	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="background-color: #d3d3d3;">ETHICS PROTOCOL NUMBER</td> <td style="background-color: #d3d3d3;">14-379</td> </tr> <tr> <td colspan="2" style="background-color: #d3d3d3; font-size: small;">Minimal Risk - Delegated</td> </tr> <tr> <td>ORIGINAL APPROVAL DATE:</td> <td>16-Feb-15</td> </tr> <tr> <td>APPROVED ON:</td> <td>16-Feb-15</td> </tr> <tr> <td>APPROVAL EXPIRY DATE:</td> <td>15-Feb-16</td> </tr> </table>	ETHICS PROTOCOL NUMBER	14-379	Minimal Risk - Delegated		ORIGINAL APPROVAL DATE:	16-Feb-15	APPROVED ON:	16-Feb-15	APPROVAL EXPIRY DATE:	15-Feb-16
ETHICS PROTOCOL NUMBER	14-379										
Minimal Risk - Delegated											
ORIGINAL APPROVAL DATE:	16-Feb-15										
APPROVED ON:	16-Feb-15										
APPROVAL EXPIRY DATE:	15-Feb-16										
PROJECT TITLE: Developing a Cultural Safety Intervention for Clinicians: A Pilot Study RESEARCH TEAM MEMBER: None DECLARED PROJECT FUNDING: None											
CONDITIONS OF APPROVAL											
This Certificate of Approval is valid for the above term provided there is no change in the protocol. Modifications To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol. Renewals Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date. Project Closures When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.											
Certification											
This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Participants. Dr. Rachael Scarth Associate Vice-President Research Operations											

Certificate Issued On: 16-Feb-15

14-379 Hall, Karen

Appendix J

NWT Scientific Research License

Licence No. 15626 File No. 12 410 816 February 19, 2015	
2015 Northwest Territories Scientific Research Licence	
<i>Issued by:</i>	Aurora Research Institute – Aurora College Inuvik, Northwest Territories
<i>Issued to:</i>	Ms. Karen Hall University of Victoria 215-100 Beck Court Yellowknife, NT X1A 3Y5 Canada Phone: (867) 447-3705 Email: doxhao@uvic.ca
<i>Affiliation:</i>	University of Victoria
<i>Funding:</i>	GNWT Department of Health & Social Services
<i>Team Members:</i>	
<i>Title:</i>	Developing a Cultural Safety Intervention for Clinicians: A Pilot Study
<i>Objectives:</i>	To develop a cultural safety intervention for clinicians through assessing the process of the pilot intervention and making recommendations to the intervention's design, content, and deliver.
<i>Dates of data collection:</i>	February 20, 2015 to December 31, 2015.
<i>Location:</i>	Cassidy Point at Aurora Village Lodge
Licence No 15626 expires on December 31, 2015 Issued in the Town of Inuvik on February 19, 2015	
Pippa Secombe-Hiett Director, Aurora Research Institute	