INDIGENOUS HEALTH NETWORK

Hamilton Niagara Haldimand Brant
Local Health Integration Network

HNHB LHIN

Summary Report

Evaluation of Indigenous Cultural Safety Training and Next Steps for Mainstream Frontline Healthcare Workers

A report based on a community engagement event hosted in Hamilton on February 28, 2019

March 2019

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Acknowledgements

We acknowledge the land upon which the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) is located, as the shared traditional territory of the Haudenosaunee and Anishnaabe Peoples, protected by the Dish with One Spoon Wampum Belt.

This historic peace agreement between the Iroquois Confederacy, the Anishinaabe and allied nations represents a commitment to share and protect the land, water, plants, and animals, with respect. There are many dialects to the Indigenous Languages and one variation for this report will be Anishinaabe and Haudenosaunee. We wish to honor the original Peoples of this land and express gratitude for the opportunity and privilege to work with communities across this territory.

Nia:wen, Chi-Miigwech, to Cam Hill for setting our minds on a good path to begin the day and to Vanessa Ambtman-Smith and Amber Brooks for expertly facilitating throughout the day.

This report was compiled jointly by the HNHB Indigenous Health Network (IHN) and the HNHB LHIN.

The HNHB IHN is a voluntary group of Indigenous health and social service leaders from two First Nation communities and 15 Indigenous organizations across the HNHB region.

Introduction

On February 28, 2019, the Hamilton Niagara Haldimand Brant (HNHB) Indigenous Health Network (IHN) hosted a community engagement event for mainstream healthcare workers who have completed online Indigenous Cultural Safety (ICS) training to evaluate the benefits of the online training program and offer additional information and training to further their personal and professional development towards cultural safety and reconciliation. The event was held at Honouring the Circle in Hamilton and was attended by 47 individuals including 7 IHN members. Please see Appendix A for list of attendees.

The purpose of this gathering was to invite mainstream healthcare workers who had already completed online ICS training to attend a community engagement event to acknowledge these individuals for beginning of their educational journey towards becoming culturally safe, understand the outcomes and benefits of the online ICS program, and provide additional knowledge and training to further their personal and professional development towards becoming culturally safe.

The engagement session began with a traditional opening by Cam Hill, who generously shared his wisdom with all participants. Following the traditional opening, HNHB LHIN Hamilton Sub-Region Director Claire Kislinsky then delivered a land acknowledgement and brief education on the reason for and importance of beginning meetings and gatherings with a land acknowledgement.

Claire Kislinsky shared with all attendees that a land acknowledgement is a formal statement that recognizes the unique and enduring relationship that exists between Indigenous Peoples and their traditional territories. To recognize the land is an expression of gratitude and appreciation to those on whose territory you reside, and is a way of honouring the Indigenous peoples who have been living and working on that land from time immemorial.

At the start of the day, participants engaged in a movement activity to encourage introductions and networking amongst all participants. Vanessa Ambtman-Smith expertly facilitated the day and began by outlining the intent of the day for all participants:

1. Understand what it means to be an ally
2. Be equipped with a new tool (Anti-Discrimination Response Training) to move from bystander to ally
3. Be equipped with exercises and knowledge to create your own bundle of tools around Allyship

Throughout the session, participants were asked to consider examples and evidence of negative health outcomes that Indigenous Peoples experience across Canada and in Ontario, and how to act as allies to interrupt acts of discrimination and racism and provide culturally safe care.

A summary of the event, including outcomes and feedback, has been captured in the report. The information in the report provides valuable perspectives that will help to guide and inform Indigenous Cultural Safety training across the HNHB LHIN.

Report on Day's Activities Including Outcomes and Feedback

Carolynne's Story

Carolynne's story was a powerful component of the online ICS training program. Carolynne's story was reviewed with all participants as a refresher from the online ICS training. In Carolynne's story, Carolynne shared her mother's experience as a hospital patient. Carolynne's mother was admitted to hospital due to complications resulting from her diabetes. While in hospital, Carolynne's mother became agitated and was moved by staff to the detox ward of the hospital. This move was made without medical evidence and without discussing the move with Carolynne's mother or her family.

Vanessa Ambtman-Smith led participants through an analysis of the stereotypes, prejudice and discrimination present in Carolynne's mother's patient experience.[1] See Figure 1 for a summary of participant feedback when considering the examples of stereotypes, prejudice and discrimination present in Carolynne's story.

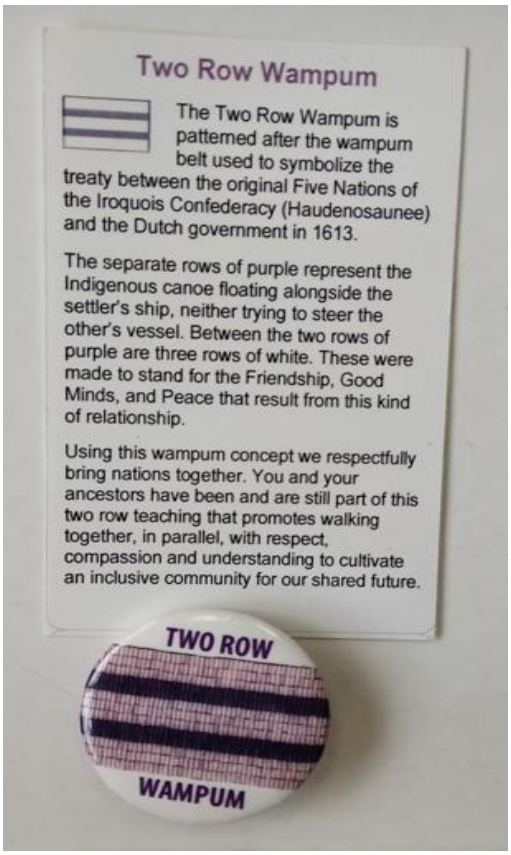
Figure 1: Summary of participant analysis of Carolynne's Story

Stereotypes	Prejudice	Discrimination
• All Indigenous Peoples use/abuse alcohol	• Healthcare workers assumed Carolynne's mother was drunk/a heavy drinker and that her agitated behaviour was because she was detoxing from alcohol use/abuse	• Healthcare workers moved Carolynne's mother to a detox ward despite a lack of medical evidence that she was detoxing – including an admission form noting that Carolynne's mother never drank alcohol
• Indigenous Peoples aren't capable of caring for themselves properly	• Healthcare workers asked Carolynne repeatedly how much alcohol her mother drank and did not believe Carolynne's assertion that her mother never drank alcohol	• Healthcare workers did not believe Carolynne and her family when they asserted that their mother did not drink alcohol, and kept her in the detox ward inappropriately for an extended period of time

Many participants were visibly upset as they viewed Carolynne's story. This is a natural response to the content and helps to demonstrate that people can connect to the inhumanity of the situation. Participants were able to identify the stereotypes, prejudice and discrimination in Carolynne's story, and were able to relate Carolynne's story to other incidents of racism or stereotyping that they have witnessed in the healthcare sector.

[1] **Definitions**
Stereotype: An exaggerated, oversimplified, fixed image, often negative, held by persons, groups and systems.
Prejudice: Preconceived opinions based on stereotypes. Results in consistent, interconnected ways of thinking and understanding.
Discrimination: Actions or inactions based on prejudice – made possible/condoned implicitly or explicitly by systemic, structural power

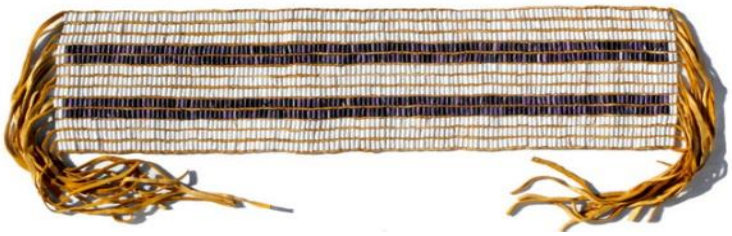
Two Row Wampum Education



The Two Row Wampum is patterned after the wampum belt used to symbolize the treaty between the original Five Nations of the Iroquois Confederacy (Haudenosaunee) and the Dutch government in 1613.

The Haudenosaunee see the Two Row Wampum as a living treaty; a way that they have established for their people to live together in peace; that each nation will respect the ways of the other as they meet to discuss solutions to issues that come before them.

Information on the history and significance of the Two Row Wampum was shared with all participants. At the same time an education card and pin were given to each participant. The intent of giving these education cards and pins to each participant was to provide further information on the importance of the Two Row Wampum, and to provide a small gift from the IHN to acknowledge the progress already being made by participants in their path towards Allyship. Participants were asked to wear these pins on their work lanyards as a symbol to any Indigenous people that they may interact with that they are working towards becoming allies and will provide culturally safe care.



Anti-Discrimination Response Training

In the afternoon, participants engaged in anti-discrimination response training (A.R.T). The session began with important context information about A.R.T.

A.R.T was developed by Dr. Ishu Ishiyama at the University of British Columbia. It is a witness-centred approach based on an experiential learning format in a group context. The benefits of A.R.T includes that it is learnable, a fun, group-based and group-building activity, is transferable to other situations, promotes empathy, increases social responsibility and ethical awareness, and empowers learners. In A.R.T there are four levels of witnessing in relation to discriminatory incidents/actions:

1. Dis-Witnessing
    a. People engaged in dis-witnessing may join the offender in their discriminatory behaviour. They may also disengage, avoid, dismiss or deny the incident. They may feel that they don't see anything wrong with the situation or that the perpetrator is really the victim. They may also feel that it's none of their business or that the victim should take care of him/herself. They may wish to be unnoticed or remain anonymous in relation to the situation.
2. Passive Witnessing
    a. People engaging in passive witnessing may be silent witnesses or may hesitate to act. They may hope that someone else will deal with the situation, feel that the victim's own kind should help them, be afraid to get involved, fear retaliation by the perpetrator, be afraid they will do or say the wrong thing to make the situation worse, or simply feel that they don't know what to say or do in the moment.
3. Active Witnessing
    a. People engaging in active witnessing may interrupt the discriminatory situation and express their own feelings with statements like "I can't believe this is being said," "I'm surprised this is being said," "I disagree and think you're being discriminator," etc. Active witnesses put the perpetrator on the spot and try to help the perpetrator self-reflect. Active witnesses also engage with the victim to affirm that they are not along, that they will assist in getting help, or will be a witness to what happened if it is reported.
4. Ethical Witnessing with Social Action
    a. People engaging in ethical witnessing go beyond active witnessing by recognizing the social injustice taking place and taking action at a societal level to confront and educate others. Ethical witnesses become agents for societal and institutional change.

After receiving information on anti-discrimination response training, including how to be active and ethical witnesses, participants broke into small groups to develop scenarios involving stereotyping, prejudice and discrimination in the healthcare sector as well as interventions using the A.R.T model to interrupt. The purpose of this group work was to provide participants with the opportunity to practice unpacking situations of harm and develop confidence in responding in a safe, constructive and supportive way.

Every group acted out their scenario in front of the larger audience and after each group scenario the facilitator led all participants through an analysis of the harmful behaviour being portrayed, as well as the A.R.T models and tools used to interrupt the behaviour.

Group scenario from the day:

An Indigenous family (mother, father and teenage daughter) came to a hospital Emergency Department. The parents were concerned because their daughter's behaviour had changed recently, including getting into fights at school, scratches and scars on her arms, and general sullenness. The parents were concerned for their daughter's mental health and overall well-being, but she did not want to be at the Emergency Department.

While in the Emergency Department a nurse took the family's information and noted the parent's concern regarding their daughter's behavioural changes. Then a psychiatrist came to assess the daughter and immediately determined, without proper assessment or conversation with the daughter or her family, that she had Borderline Personality Disorder and was suicidal. The doctor immediately ordered an in-patient stay and medication. The nurse attempted to interrupt the psychiatrists racist assumption that the daughter must have a mental illness, but with limited success.

While this was happening, a social worker made a connection to the daughter by taking an open and empathetic approach when asking how she felt. The daughter then shared that she was being bullied and called racist names at school, which had prompted her fights and general sullenness. The daughter also advised that she had resisted telling her parents about this because she was experiencing racism for being Indigenous and knew it would hurt her parents to know the truth. The social worker asked the daughter if she would be comfortable with weekly sessions to discuss the challenges she was experiencing as well as more positive coping mechanism. The daughter agreed.

The social worker then tactfully interrupted the psychiatrist, shared her update, and confirmed with the parents that they were supportive of her approach and happy that their daughter was comfortable with the proposed course of treatment.

The social worker and nurse were able to work together to interrupt the psychiatrists racist behaviour, provide compassionate support for the family, and assure the family that they would support the family in reporting this behaviour to the appropriate body at the hospital.

All participants analyzed this group scenario and determined that the harmful behaviour was the psychiatrists immediate assumption that the Indigenous patient had a significant mental illness (Borderline Personality Disorder) and that their immediate course of treatment was an inpatient stay away from family and community as well as medication.

The A.R.T models and tools used to interrupt this harmful behaviour included engaging in active witnessing to interrupt and question the psychiatrist's racist behaviour as well as providing compassionate and empathetic care to the patient and her family.

Summary

Reconciliation does not start with Indigenous people alone: it must be a collaborative effort from both Indigenous and non-Indigenous Canadians. Connections continue to exist between colonial narratives/bias and attitudes that reinforce racist stereotypes and behaviour.

In the healthcare system, the result of racist stereotypes and behaviour is the proliferation of harm or poor care for Indigenous peoples.

Recommendations

A key recommendation from this engagement session was that additional education opportunities, both online and in-person, are required to support mainstream healthcare workers in their progress towards becoming allies. One online course, or attendance at one in-person, one-day event, is insufficient to become an effective ally. The HNHB Local Health Integration Network is committed to continuing to invest in online ICS training for mainstream healthcare workers across the LHIN, and the HNHB IHN is committed to continuing to host community engagement events such as this event.

Next Steps

This report has been developed as a resource for non-Indigenous health system partners as a resource to support personal and professional development towards becoming allies. The information captured in this report is a useful first step but additional education, both online and in-person, is necessary.

Participants at this community engagement event were offered the opportunity to participate in online ICS post-training, *From Bystander to Ally*, to further support their education. The *From Bystander to Ally* course provides additional information on identifying and interrupting racist and discriminatory behaviour and provides opportunities for participants to explore scenario-based racism in the healthcare system, similar to Anti-Discrimination Response Training. Anyone interested in taking online ICS training or *From Bystander to Ally* post-training should contact Kelly Cimek, Director of Planning, at kelly.cimek@lhins.on.ca for additional information.

The HNHB IHN anticipates planning additional community engagement events and gatherings in 2019-20 to continue to facilitate opportunities for mainstream healthcare workers to continue their education to become allies who provide culturally safe care for Indigenous peoples.

Contact Us

If you have any questions pertaining to the content of this report, or the work of the HNHB Indigenous Health Network, please contact Kelly Cimek, Director of Planning at kelly.cimek@lhins.on.ca or 1-866-363-5446 ext. 4249.

Appendix A: Attendance List

Name	Organization
Karen Babcock	HNHB LHIN Health Links
Roslynn Baird	Indigenous Diabetes Health Circle
Lisa V. Bomberry	Six Nations Health Services
Nancy Candy-Harding	CAMHS Haldimand Norfolk
Kelly Cimek	HNHB LHIN
Janice Cochrane	St. Joseph's Healthcare Hamilton Labour and Delivery
Claire Collison	Hampton Terrace Care Centre
Lisa Connolly	De dwa da dehs nye>s
Fran Davis	Consultant with Niagara Region Public Health
Carolyn Day	Niagara Chapter - Native Women's Inc.
Jennifer DeSimone	HNHB LHIN Health Links
Jennifer Dockstader	Fort Erie Native Friendship Centre
Manoj Edamana	Niagara Health
Colin Fenwick	Niagara Medical Group Family Health Team
Emmeline Gregoroff	HNHB LHIN
Helen Harris	St. Joseph's Healthcare Hamilton
Janis Hibbs	ARID (Wish) Recovery Home
Sherry Hoffman	Hampton Terrace Care Centre
Maggie Irving	HNHB LHIN
Michelle Jamieson	Hampton Terrace Care Centre
Claire Kislinsky	HNHB LHIN
Cindy Knaus	West Haldimand General Hospital
Mike Lambert	ARID (Wish) Recovery Home
Katie MacNeil	Niagara Medical Group Family Health Team
Kate MacNeil	De dwa da dehs nye>s
Kelly L. Martin	West Haldimand General Hospital
Joanna Mataya	Hospice Niagara
Kitten Moses	Fort Erie Native Friendship Centre
Angela Naveau	De dwa da dehs nye>s
Kathryn Newhouse	Family Counselling Centre of Brant
Cassie Ogunniyi	Niagara Region Public Health
John O'Neill	St. Joseph's Healthcare Hamilton
Sarah Page	Norfolk County Paramedic Service
Nicole Rakowski	HNHB LHIN Health Links
Wendy Renault	Haldimand War Memorial Hospital
Jodi Rock	HNHB LHIN Indigenous Health Links Lead
Lori Schiappa	HNHB LHIN Health Links
Alexandra Scordas	Niagara Region Mental Health
Leslie Stephenson	March of Dimes
Melissa Skeoch	Niagara Region Mental Health
Wendy Sturgeon	Niagara Chapter - Native Women Inc.
Tina VanEgmond	Hospice Niagara
Kelly Vlaar	Hospice Niagara
Nancy Williams	West Haldimand General Hospital
Erica Wright	Behavioural Supports Ontario Case Manager, Haldimand Norfolk Alzheimer's Society