

# DISMANTLING ANTI-INDIGENOUS RACISM WITHIN THE HEALTH CARE SYSTEM

Final Report of the  
2019 Think Tank on  
Anti-Indigenous Racism

Vancouver, BC  
March, 2019

*all meetings  
are transformations*

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# EXECUTIVE SUMMARY

## ABOUT THE THINK TANK

On March 12, 2019, 35 health leaders met in Vancouver, British Columbia to participate in a Think Tank about anti-Indigenous racism and cultural safety within the health care system. The objectives were to:

- **Promote collaboration** in addressing racism and disrupting harm to Indigenous people in the health care system.
- **Create a cross-system framework** to address anti-Indigenous racism within PHSA and provincially.

**Dr. Cheryl Ward (Executive Director of Indigenous Cultural Safety and Strategy for the Indigenous Health department within the Provincial Health Services Authority or PHSA) convened the Think Tank**, a day of presentations and facilitated discussion. It included participants from the following organizations:

- Provincial Health Services Authority (PHSA)
- Island Health
- Northern Health
- Fraser Health
- First Nations Health Authority (FNHA)
- British Columbia Ministry of Health
- British Columbia Patient Safety and Quality Council
- Métis Nation British Columbia (MNBC)
- British Columbia Association of Aboriginal Friendship Centres (BCAAFC)
- Manitoba Regional Health Authority
- Shared Health Manitoba
- University of Manitoba
- Ontario Indigenous Cultural Safety Program
- Simon Fraser University

## OVERVIEW

Initially, Jane Collins (Indigenous Health, PHSA) shared the findings of a recent analysis of data from the San'yas Indigenous Cultural Safety training program identifying the harms occurring to Indigenous people in the BC health care system. Dr. Barry Lavallee (formerly of the University of Manitoba) addressed institutional anti-Indigenous racism and strategies to intervene. Dr. Collin van Uchelen (Indigenous Health, PHSA) then invited participants to reflect on, respond to, and share their ideas related to the following **questions**:

- **What forces hold these harms and layers of racism in place?**
- **Who or what is complicit in perpetuating these harms?**
- **How do we continue these systems of harm?**
- **How do we dismantle these systems?**



# KEY FINDINGS

## WHAT IS HOLDING ANTI-INDIGENOUS RACISM IN PLACE?

Participants categorized the factors that perpetuate anti-Indigenous racism under the following headings: *interpersonal*, *organizational* and *systemic*.

- **Interpersonal racism** is due to gaps in knowledge, education, skills and awareness of those working within the health care system. It manifests as resistance: a refusal to change one's behaviour when confronted with concerns about race, racism and colonization. This could be due to disbelief, discomfort and/or defensiveness.
- **Organizational racism** makes it difficult to confront racism because it allows people to normalize, hide or disguise it. There is a lack of accountability, a lack of leadership to stop racist approaches or behaviours, and an absence of policies or processes to effect change. When Indigenous people are hired, they are underrepresented and their presence on staff smacks of tokenism. In addition, Indigenous racism is viewed through the lens of multiculturalism, with little or no acknowledgement of colonialism and colonial oppression.
- **Systemic racism** acknowledges that anti-Indigenous racism is embedded in all public institutions, not just the health care system. It is woven into the very fabric of Canadian society. The ways in which power inequities serve to reinforce this reality are readily apparent across sectors (e.g., education, justice, the media) and highlighted when reviewing the pervasive funding inadequacies for Indigenous programs and communities.

# RECOMMENDATIONS



## INTERPERSONAL RACISM

- Mandate anti-racist cultural safety training for all health care employees.
- Establish peer-support networks to help employees' practice what they learn.



## ORGANIZATIONAL RACISM

- Establish and sustain an Indigenous-led leadership group.
- Harmonize organizational policies, practices and norms to support anti-racism and cultural safety.
- Establish protocols for accountability, monitoring and evaluation, in response to anti-Indigenous racism.



## SYSTEMIC RACISM

- Support initiatives in other sectors that also are focused on interrupting racism and discrimination.

# ANTI-INDIGENOUS RACISM & STRATEGIES TO INTERVENE

Drawing on his experiences as a physician, researcher, and medical school professor, Dr. Barry Lavallee began his presentation on intervention strategies by exploring the origins and purpose of the concepts of race, racialization, and Indigenous-specific racism. Making explicit connections between each, he linked them to the violence experienced by Indigenous people within the health care system.

Dr. Lavallee maintained that dehumanization, a colonial tactic that has been used for thousands of years yet documented only recently, is at the core of this violence.

*Dr. Lavalee recalled the tragic death of Brian Sinclair, a Cree man who sought emergency assistance at the Winnipeg Health Sciences Centre emergency room. Ignored and left sitting in his wheelchair without attention for 34 hours, he died of sepsis for what turned out to be a treatable bladder infection. His death, and the inquiry that followed, are a stark example of the dehumanization of Indigenous people within health care that is still happening today.*

Drawing parallels between Brian's story and the behavior witnessed by Indigenous medical students, Dr. Lavallee offered the following **strategies to address institutionalized Indigenous-specific racism**:

- **Acknowledge and deal with "socially-acquired blindness"**, (the ways in which people are conditioned not to perceive racism as real or as a problem, and as a result, fail to perceive harm to Indigenous people)
- **Hold each other to account through policies and actions**
- **Be prepared to terminate someone if racist behaviours persist**, thereby responding to racist actions/behaviours with concrete consequences
- **Build anti-racism into medical school curricula and all training for health professionals**
- **Most importantly, create systems where Indigenous community members are asked about the care they have received** (i.e., involve Indigenous patients and family members in the evaluation and monitoring of their care)

## FACTORS PERPETUATING ANTI-INDIGENOUS RACISM

Reflecting on Dr. Lavallee's insights into anti-Indigenous racism, participants discussed the following questions:

- **What forces hold the harms and layers of racism in place?**
- **Who or what is complicit in perpetuating them?**
- **How do we continue these systems of harm?**

Discussion outcomes were summarized and organized into the key themes (listed on p. 7).

For a full list of comments, refer to Appendix B.

## INTERPERSONAL RACISM



### LACK OF KNOWLEDGE, SKILLS, AND AWARENESS

Participants noted that **gaps in the knowledge, self-awareness, and skills of individuals within the health care system hold anti-Indigenous racism in place**. They also expressed concern about the *lack of education* about racism, colonialism, and Indigenous people, and observed that many *people do not know how to intervene or are afraid to intervene when they witness racism*.

### RESISTANCE

**Resistance refers to the ways in which people express disbelief, discomfort, and defensiveness in facing race, racism, and colonization.**<sup>1</sup> Reactions differ, based on identity and social location,<sup>2</sup> but resistance manifests in common tactics and distancing behaviours that reflect a refusal to change. This results in action or inaction in the face of harm<sup>3</sup> as described in the forms of resistance listed below:

- *denial*, such as the denial of the truth about colonialism and racism
- *blame*, as in blaming individuals for situations in which they find themselves (as a result of various societal factors out of their control, such as systemic racism)
- *avoidance*, by shifting the focus to other issues, or by asking about other oppressed groups
- *inaction*, borne of a fear of alienation, social rebuke, or loss of privilege when speaking out against anti-Indigenous racism

## ORGANIZATIONAL RACISM



### PRACTICES THAT NORMALIZE, HIDE OR MAKE IT DIFFICULT TO ADDRESS RACISM

**Participants identified a number of everyday practices that normalize or disguise racism, making it difficult to address.** These practices are linked to organizational culture and serve to reinforce anti-Indigenous racism.

They also result in “inaction in the face of need,” which is iterated in the description of institutional racism offered by physician and activist Camara Phyllis Jones. Everyday practices include:

- *protection from criticism* (e.g., organizations seeking to avoid litigation fail to hold employees accountable for harm and remain silent to avoid challenge and controversy)
- *discomfort with change* (e.g., a preference for maintaining the status quo)
- *maintenance of a “stay positive” attitude* (undermining efforts to establish real change and accountability by maintaining values and beliefs that are “non-disruptive”)
- *grooming of peers and employees* (reinforcing racist perceptions by “grooming” peers and employees to develop and foster an anti-Indigenous mindset.<sup>4</sup>)

## LACK OF ACCOUNTABILITY, MONITORING, AND EVALUATION

One of the most salient themes that emerged during the Think Tank was the need for better and more consistent monitoring, evaluation, and accountability processes. How organizations respond when harm occurs is critically important. Participants cited complaints processes that often are unsatisfactory to patients and staff. Too often **Indigenous patients and staff have reported that “no action was taken on reports of racism.”**

## LEADERS FAILING TO ACT, OR ACTING IN WAYS THAT IMPEDE AN ANTI-RACIST OR INDIGENOUS CULTURAL SAFETY AGENDA

Participants acknowledged the critical role that leaders play in either upholding or interrupting anti- Indigenous racism within their organizations. Leaders can prevent/impede change when, for example:

- **they fail to make anti-Indigenous racism a priority**, by showing “no organizational mandate for change”
- **they fail to take action**, by continuing to use assessments that have been shown to harm Indigenous people; by overlooking racist beliefs, attitudes, and behaviours of employees and leaders; by demonstrating inaction in the face of hard evidence that an organizational practice or person is racist
- **they fail to address anti-Indigenous racism within organizations**, by upholding the status quo; by refusing to engage anti-Indigenous racism experts; by making no provisions within the budget to address racism; by engaging people to lead organizational change who lack the skills/knowledge to address these pressing and recurrent issues.

## POLICIES AND POLICY PROCESSES BEING RIGID AND RESISTANT TO CHANGE

Participants took issue with the rigidity of policies and practices within mainstream health care organizations. Some participants explained that the **settler-imposed policymaking process** reinforces this rigidity (e.g., ‘settler’ planning that is scheduled on three-, four-, and five-year cycles; lack of long-term planning; coding race into policies and guidelines with no plans to change, adjust, or examine them over time. Other participants noted how **policy is emphasized and adhered to as an excuse for harmful behaviour**. for example, hiding behind policies or guidelines that have become norms (e.g., ‘triage this way,”) and overlooking policy breaches when harmful practices are employed (e.g., employees not acting as per policies when working with Indigenous people).

## UNDERREPRESENTATION AND TOKENISM OF INDIGENOUS STAFF

Participants articulated some of the challenges that Indigenous people face when working in mainstream health care organizations. In general, Indigenous people remain underrepresented in the health workforce and in leadership positions. Compounding this, Indigenous staff, when present, are:

- **often tokenized** (see Appendix A: Glossary)
- **relied upon to “fix” racism within the organizations**, which means they bear the brunt of the work and are often solicited to provide anti-racism knowledge and expertise
- **placed in roles or on committees that pay lip service** to, but do very little to ameliorate, anti- Indigenous racism and culturally unsafe health care
- **labeled as problematic** for speaking out against racism and subsequently dismissed as troublesome



Participants also gave examples of how non-Indigenous leaders can intentionally and unintentionally create barriers that limit the success of Indigenous leaders, staff, and approaches to practice. Specifically, there is a lack of adequate mentorship or employment supports, by implementing “colour blind” standards in training and performance measurements, Indigenous staff are set up to fail (e.g., hiring and training Indigenous staff according to standards of professionalism and definitions of “good leaders” that were developed without input from Indigenous communities and that are based on Eurocentric norms and standards<sup>5</sup>).

## NARROW INTERPRETATIONS OF “CULTURE”: MULTICULTURALISM

In Canada, “culture” is often viewed through the lens of multiculturalism. Multiculturalism has received heavy criticism for homogenizing diverse groups, thereby erasing the impact of power inequities in the name of “egalitarianism,” and enabling stereotyping.<sup>6</sup> For Indigenous people, multiculturalism ignores/overlooks the colonialism they have and continue to endure and the colonial oppression that they face. While sovereignty and decolonization address Indigenous oppression, multicultural equality does not.<sup>7</sup> Furthermore, multicultural approaches promote the narrow understanding that culture is a static, measurable concept that only includes the “superficial” expressions of a community’s way of life (e.g. dance, dress, food, and customs).<sup>8</sup>

This perspective engenders the belief that the cultures of Indigenous people (rather than the systems of oppression at play) are the problem, and/or that teaching about Indigenous cultures (rather than the realities of anti-Indigenous racism) will reduce harm and make care more culturally-safe. These approaches inadvertently place the onus on Indigenous people to “fit in, or do a better job of explaining themselves, healing themselves, or abandoning their culture.”<sup>9</sup> Research shows that education approaches that critically examine anti-Indigenous racism and how “the culture of medicine... perpetuate[s] systems of oppression” can have a greater impact on health care experiences and outcomes.<sup>10</sup>

**There was some discussion about how a multicultural approach has infiltrated the health care system.**

**Overall, participants found this approach challenging because it tends to:**

- *reduce anti-racism and cultural safety work to a checklist*
- *ignore the harms caused by racism, and the reality that racism is a patient safety issue*
- *fall short of addressing the systemic and structural root causes of health disparities*



# SYSTEMIC RACISM



## ANTI-INDIGENOUS RACISM ENCODED IN INSTITUTIONS THAT INFLUENCE HEALTH CARE

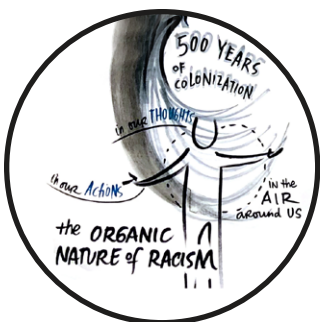
Participants recognized that anti-Indigenous racism is embedded not only in the health care system, but **in all public institutions**, including education, justice (as evidenced in the over-policing and over- incarceration of Indigenous people, especially Indigenous women) and the media (as is clear in the newspapers and social media that promote racist perspectives). With anti-Indigenous racism woven into the very fabric of Canadian society, encoded in legislation, and **constantly reinforced through social norms across generations**, tackling issues in the health care system independent of other sectors can seem daunting. Nevertheless, participants were confident that change is possible and already underway.

## POWER IS STRUCTURED IN WAYS THAT MAINTAIN STATUS QUO

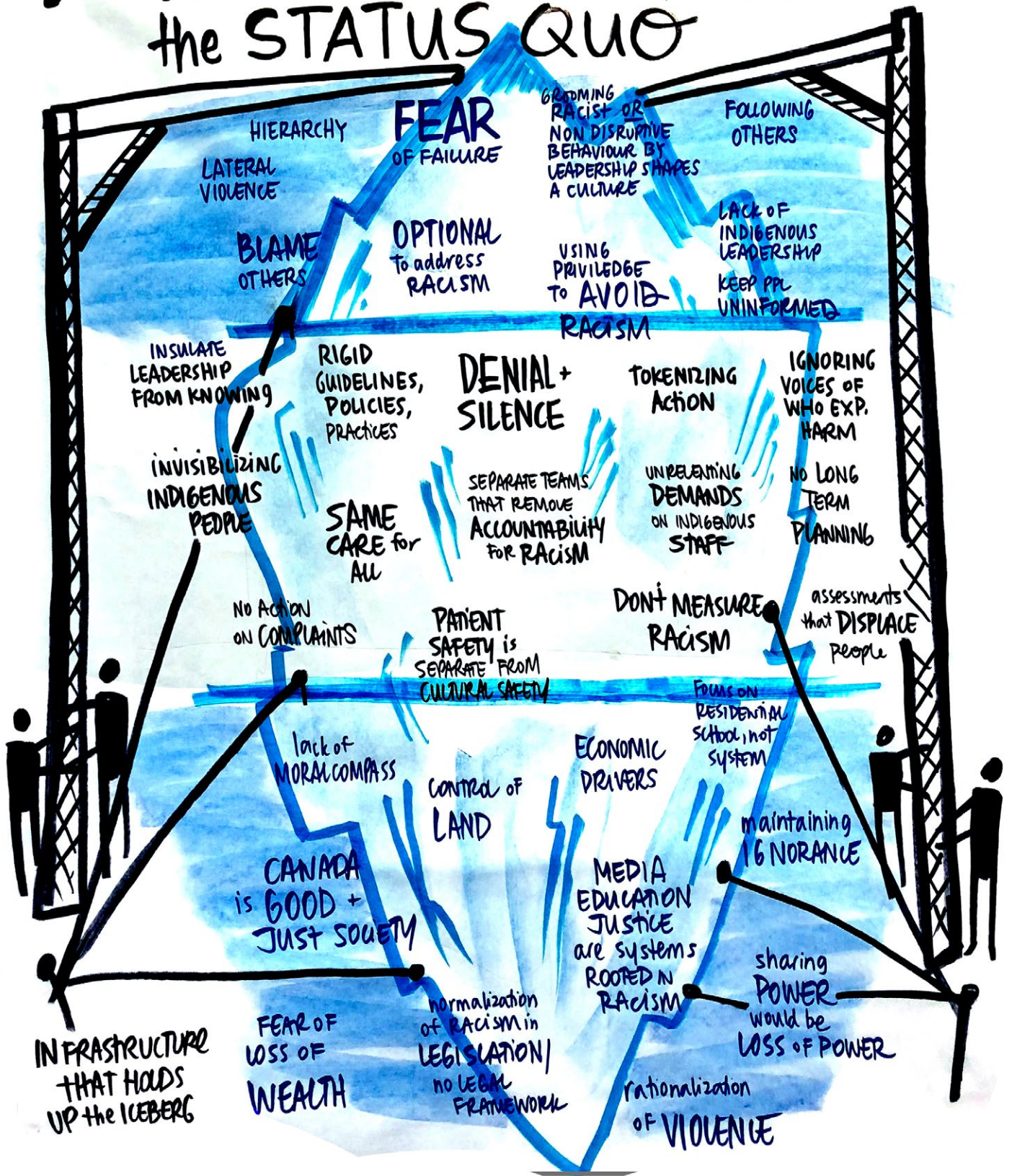
Attention was drawn to the ways in which power is structured in Canada to maintain the settler -colonial status quo (i.e., a relationship of dominance). These broader power inequities have both direct and indirect impacts on Indigenous health and serve to reinforce anti-Indigenous racism inside and outside the health care system.

Specifically, power was conceptualized as:

- **wealth and economic opportunities** (Indigenous communities receive less funding for health services and basic needs than non-Indigenous Canadian populations; Indigenous people are blamed for circumstances that are linked to poverty, imposed by settler colonial systems)
- **knowledge** (Western, biomedical knowledge continues to dominate the health care system; high quality, ethical population-level health data on Indigenous people is lacking)
- **decision-making** (people in power have a vested interest in maintaining the status quo)



# FORCES that MAINTAIN the STATUS QUO



Graphic recording by Sam Bradd | Drawing Change: What is Holding Anti-Indigenous Racism in Place?

# DISMANTLING ANTI-INDIGENOUS RACISM

Participants reflected upon and discussed this question:

***How do we dismantle the organizational systems that create anti-Indigenous racism and hold it in place?***

## ALIGNMENT AND COLLABORATION

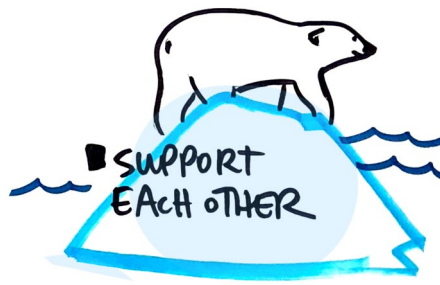
Participants agreed that increased collaboration is essential within the health care system and across other sectors to disrupt anti-Indigenous racism. The anti-racism and cultural safety work that is happening across the province must be shared. With that in mind, participants offered the following recommendations:

- ***create mechanisms for sharing and implementing successful anti-Indigenous racism strategies*** (e.g., establishing a place where people can find, learn, and share knowledge about what has worked)
- ***create an environment that is conducive to ongoing dialogue and the establishment of priorities*** (e.g., host additional Think Tanks; devise ways to work together to align strategies, policies, and interventions)
- ***collaborate with sectors outside the health care system*** (e.g., child welfare, education, justice) to effect cross-system change
- ***provide cross-sectoral support and resources to maintain the energy, well-being, and focus*** of the people doing this work

## ACCOUNTABILITY, MONITORING, AND EVALUATION

It is essential to build a strong and immediate process for reporting and responding to concerns about anti-Indigenous racism. This is the imperative of responding to harm. Strategies may include the following actions:

- ***create safe and fair processes to address complaints*** (e.g., create new systems and expand/enhance existing capacities; increase the number of Indigenous Patient Navigators and include complaint reception in their job descriptions; create structures/policies within the health care system that ensure that it is safe to self-identify as Indigenous; ensure that harms are addressed and the data collected on complaints is managed effectively; consider whether processes should be overseen by an independent, external body;
- ***engage Indigenous communities in the creation of a responsive complaints systems***
- ***collect data on the experiences of Indigenous patients and staff*** (the San'yas program and FNHA has been identified as leaders in this work and can provide insight and support)
- ***establish and ensure “zero tolerance for racism,” both within and outside the health care system***
- ***embed racism, discrimination, cultural safety, and humility measures in monitoring processes*** (e.g., an Indigenous Cultural Safety monitoring framework)
- ***institute performance management and evaluation measures*** (e.g., annual reviews, 360 evaluations), and
- ***value the voices of Indigenous people when determining accountability*** (too often the voices of clinicians are given greater credence than the voices of patients who may have been mistreated)



## TRAINING AND CAPACITY

**The education and training of health care employees (i.e., providers, administrators, and leadership) is a critical component of this work.** Participants felt training must include:

- **content on the colonial past and present of Canada**, and its impact on Indigenous people because we need to understand the 'why' to get to the 'how' (i.e., unlearning the inaccurate, biased history taught in public education systems; supporting learners to become comfortable with discomfort which is a normal part of the transformative learning process)
- **concrete skills and strategies** that can be used by health care employees to interrupt anticipated, witnessed, or experienced racism
- **anti-racism, cultural safety content that is embedded in all curricula** (e.g., training of health care workers in professional schools, and ongoing throughout their careers)
- **learning that is lifelong** (e.g., promotion of and support for continuing education both inside and outside the workplace)
- **San'yas training** as the minimum standard for all health care employees

## MEANINGFUL ENGAGEMENT OF INDIGENOUS COMMUNITIES

**Indigenous communities, families, and patients need to be meaningfully engaged in decision-making processes at all levels of the health care system** - from programs, policies and agenda-setting to data governance and complaints processes.

**Participants agreed that Indigenous engagement is foundational, and must be both ethical, and ongoing if policies and practices** - such as complaints mechanisms - are to be safe, accountable, and meaningful. Engagement does not mean tokenizing Indigenous people or positions or continuing to place the effort and responsibility of addressing anti-Indigenous racism on Indigenous people. It requires a balance between honouring Indigenous perspectives and approaches and allocating responsibility appropriately and evenly between Indigenous and non-Indigenous stakeholders.

**Engagement must validate the life experience, pride, belief systems, and strengths of Indigenous people and nations.** Participants suggested the establishment of advisory committees and formal co-creation processes (such as a formal complaints system) when discussing community engagement. For engagement to have meaning and a positive impact there was consensus that there must be a commitment to invest in time and resources.

## LEADERS AND DECISION-MAKERS LEADING THE WAY

**Participants agreed that health leaders, and all those in positions of power, are vital to dismantling anti-Indigenous racism within the health care system.** It is important that they acknowledge that racism exists, and cultural safety is needed, and that they assume responsibility for addressing these issues by:

- ***formally committing to addressing anti-Indigenous racism***, (e.g., ensuring that organizations start by acknowledging and understanding the “truth” in truth and reconciliation)
- ***responding to relevant calls to action that uphold human rights*** (e.g., adopting all of the Calls to Action outlined in the report by the Truth and Reconciliation Commission of)
- ***investing financially in action*** (e.g., dedicating resources to cultural safety and sustaining anti-racism efforts over the short- and long-term; supporting staff training and education)

## POLICIES AND STANDARDS

**Workplace policies and standards must be mobilized to disrupt anti-Indigenous racism and discrimination.**

Participants felt that organizations should be using social justice, equity, and critical theory to inform their policy-writing and analysis. They also believe policies and policy processes should be strengthened, shifted, and – where required – newly developed to interrupt anti-Indigenous racism. Specific recommendations included:

- ***setting cultural safety hiring standards*** (e.g., developing culturally-safe interview guidelines; changing recruitment processes to support a larger, more diverse, and well-supported Indigenous workforce)
- ***instituting financial incentives or penalties to motivate change***
- ***setting cultural safety standards of practice for health care providers***
- ***accreditation of culturally-safe services and organizations***
- ***making the connection between policies, standards and accountability*** (e.g., establishing policies which identify inappropriate actions/behaviours and the steps to be taken to ensure appropriate reporting and follow up)

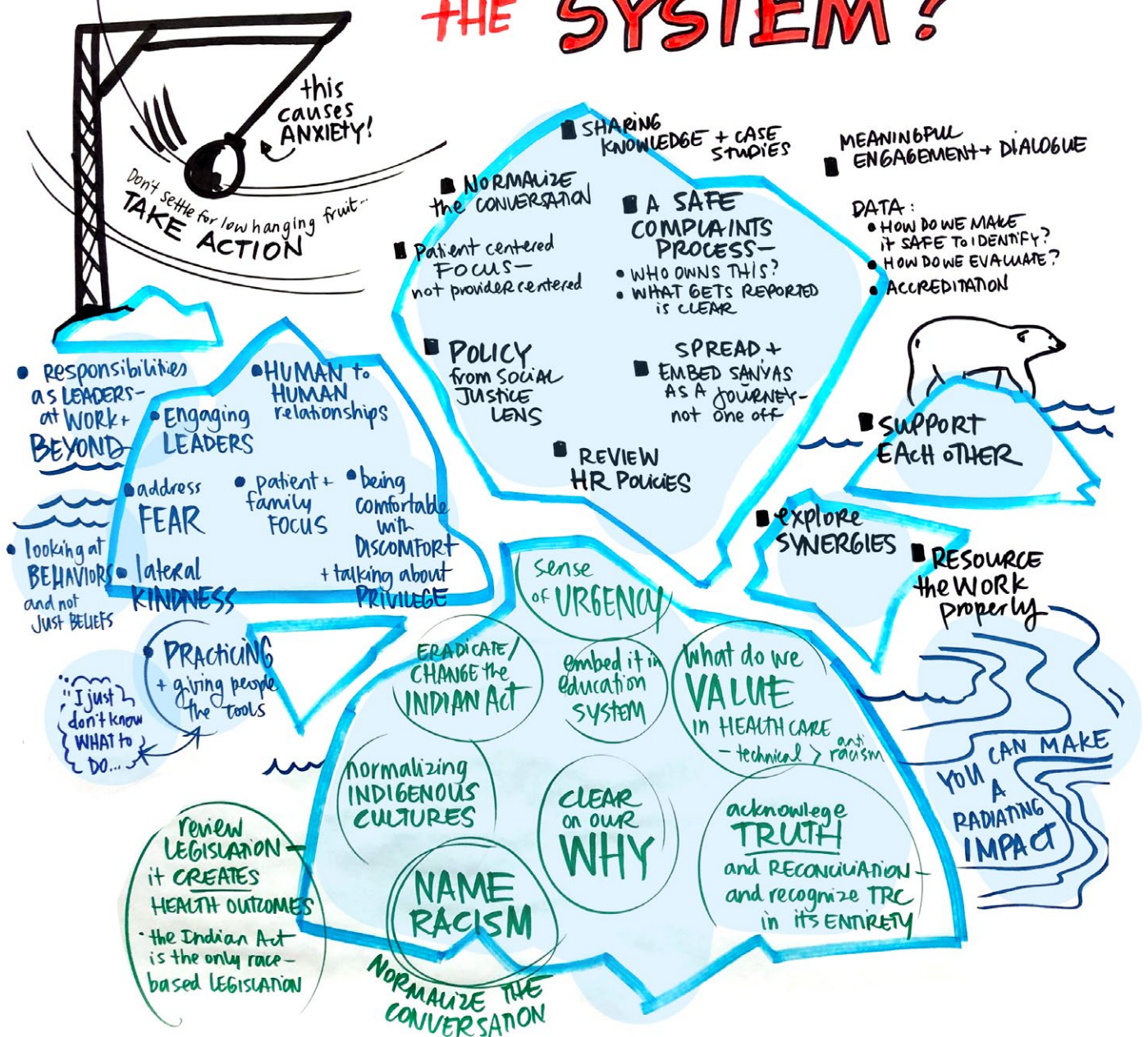
## SUPPORTING CHANGE BEYOND THE HEALTH CARE SYSTEM

**Participants also recommended strategies for change that extend beyond the scope of the health care system, such as:**

- ***identifying and dismantling legislation and policies that are racist*** (e.g., Indian Act, child welfare legislation, funding gaps)
- ***changing the curriculum in public and post-secondary education systems*** (e.g., integrate *Saṅ'ya*s training into the public and post-secondary curriculum);
- ***normalizing Indigenous culture, knowledge, and ways of knowing in mainstream society*** (e.g., in New Zealand, Maori haka – ceremonial dances – are integrated into schools)
- ***shifting dominant values and beliefs***

**Social justice, advocacy and anti-racism strategies are key to contextualizing and reinforcing the unacceptability of anti-Indigenous racism.**

# HOW CAN WE DISMANTLE THE SYSTEM?



Graphic recording by Sam Bradd | Drawing Change: illustrates the discussion about dismantling anti-Indigenous racism

# RECOMMENDATIONS

The discussions that were held at the Think Tank confirm that there are many entry points for health care providers, administrators, and decision-makers to make changes within and outside of their organizations to disrupt anti-Indigenous racism. The following recommendations address one or more of the challenges identified by participants:

## CHALLENGE: INTERPERSONAL RACISM

### Gaps in knowledge, education, skills and awareness / Resistance to change

#### > RECOMMENDATIONS

#### 1. Mandate anti-racist cultural safety training as the minimum standard for all employees within the health care organization.

- a. Provide training both during on-boarding, and on a continual basis to keep skills and competencies up-to-date, and consistent with the life-long learning imperative of cultural safety.
- b. Implement evidence-based practices for cultural safety training<sup>11</sup> including but not limited to:
  - ✓ Pedagogy that is grounded in anti-racist, decolonizing, and transformative
  - ✓ education principles that do not portray Indigenous people/cultures as problems or pathologies.
  - ✓ Training that is facilitated by qualified, interracial instructors who are supported by a community of practice.<sup>12</sup>
  - ✓ Training that provides learners with concrete strategies and skills to integrate and apply their learning to practice that is, consistent with local knowledge systems and understandings.<sup>13</sup>
  - ✓ Training that includes content and supports that meet the unique and distinct needs of learners who are Indigenous, non-Indigenous people of colour, and White settlers.<sup>14</sup>

#### • PROMISING PRACTICES:

- [San'yas Indigenous Cultural Safety Training Program.](#)

#### 2. Establish peer-support networks to help employees practice what they learn from anti-racist cultural safety training.

- a. Hire staff who will debrief employees after training; check in with employees in practice settings, and respond to questions and concerns about anti-racism and cultural safety.
- b. Establish caucus or coalition groups within organizations. Caucuses provide spaces for people to work within their own racial identity groups (e.g., distinct caucuses for Indigenous, non-Indigenous people of colour, and White people) to build capacity and support around their anti-racist work in multi-racial settings. Wise practices for caucus work include:
  - ✓ Clear objectives and monitoring/evaluations processes that help organizations to achieve social justice, inclusion, and anti-racism goals.<sup>15</sup>
  - ✓ Clear and defined processes (e.g., who facilitates, how issues are brought forward, how members communicate and hold each other accountable, and – with the exception of the Indigenous caucus – how the caucuses work together)
  - ✓ Efforts to identify and challenge patterns of White culture and privilege within the organization
  - ✓ An Indigenous caucus which provides a space for relief, peer support, and healing to address internalized, interpersonal, and organizational experiences of racism.
  - ✓ A non-Indigenous People of Colour caucus which provides a space to discuss personal experiences of racism and colonialism and how those experiences affect the work environment; as well as personal and community responses to Indigenous people.
  - ✓ A White caucus in which white settlers speak with each other about anti-racism concepts and work through their emotions, rather than relying on Indigenous people or people of colour<sup>16</sup> to do it for them. It should provide a place for critical reflection that disrupts “individual and collective habits of harm.”<sup>17</sup>

#### • PROMISING PRACTICES:

- Caucuses for staff who are Indigenous, staff who are non-Indigenous persons of colour, and white staff (e.g., as modelled by the [San'yas program](#)).
- King County Public Health Racial Caucus.
- Cup of Coffee Conversations to support professionalism ([Vanderbilt University in Tennessee](#); medical schools in [Texas](#) and [Arizona](#))



## CHALLENGE: ORGANIZATIONAL RACISM

Everyday practices that normalize, hide, or disguise racism / Lack of accountability, monitoring, and evaluation / Leaders who fail to act, or act in ways that impede an anti-racist or Indigenous cultural safety agenda / Policies and policy processes that are rigid and resistant to change / Underrepresentation and tokenism of Indigenous staff / Approaches that reflect narrow interpretations of culture

### > RECOMMENDATIONS

#### 1. Establish and sustain an Indigenous-led, strategic and tactical leadership body that will meet regularly to continue this work.

##### a. Functions of this body would include:

- ✓ Coordinating cultural safety work across various areas (including across Regional Health Authorities) to strengthen impact, and provide opportunities to compare results and share knowledge;
- ✓ Creating, implementing, sharing, and evaluating wise, evidence-based practices re: training, policies and standards (e.g., hiring, recruitment, and mentorship practices), monitoring and evaluation (e.g., complaints processes).

##### b. To ensure the body is effective and follows wise practices,<sup>18</sup> it must be:

- ✓ Led and governed by Indigenous people.
- ✓ Guided by a formal agreement (e.g., Terms of Reference, Memorandum of Understanding) articulating principles, roles, responsibilities, objectives, structure, and conflict resolution mechanisms that are co-developed and signed by members.
- ✓ Supported with dedicated and ongoing resources and funds.

#### 2. Harmonize organizational policies, practices, and norms with the principles and goals of anti-racism and cultural safety.

a. Formally commit to addressing anti-Indigenous racism by integrating anti-racism and cultural safety in an organization's strategic and operational plans and by developing a formal action plan or framework for organization-wide change.<sup>19</sup>

b. Examine, using an anti-racist, cultural safety, and health equity lens, organizational policies and procedures (including decision-making practices of boards, senior managers, and policy makers) to determine their impacts on Indigenous patients and staff. Revise policies and procedures that are harmful and exclusionary.<sup>20</sup>

#### • PROMISING PRACTICES:

- Fraser Health Service Plan 2018-19 to 2021-21
- Interior Health Service Plan 2018-19 to 2021-21
- Northern Health Cultural Safety and Humility Plan and Framework
- Vancouver Coastal Health: Aboriginal Cultural Competency Policy
- PHSA Indigenous Cultural Safety Strategy
- First Nations Health Authority 2018/2019 Service Summary Plan
- Northwest Territories' Department of Health and Social Services Commitment to Action
- National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) Cultural Safety Framework
- New Zealand Ministry of Health, Health Equity Assessment Tool (HEAT)
- Saskatoon Health Region health equity audits

## CHALLENGE: ORGANIZATIONAL RACISM

### 3. Establish protocols for accountability, monitoring and evaluation to guide organizational responses to anti-Indigenous racism.

- a. Develop a complaints system for Indigenous patients, relatives/friends of patients, and staff that is fair, safe, responsive, and easy to access. Based on the evidence,<sup>21</sup> this system should:
  - ✓ Be co-developed in partnership with an advisory council representing Indigenous patients, family members, and staff.
  - ✓ Include formal obligations for staff to report instances of anti-Indigenous racism without repercussions, and for the organization to track and publicly report all complaints.
  - ✓ Mandate comprehensive anti-racism, cultural safety training for personnel responding to complaints.
  - ✓ Offer formal supports for complainants throughout the complaints process, with clear explanations of protocols (e.g., who to talk to, how to fill out forms, etc.) and an assurance of confidentiality.
  - ✓ Implement a “no wrong door” approach, where complaints can enter the system from any person within any area of health care (i.e., receiving, delivering, evaluating or designing services).
  - ✓ Reflect restorative or other non-punitive, action-based approaches to justice, aligned with existing human rights frameworks (e.g., UNDRIP).
- b. Establish, implement, and track cultural safety indicators to assess the performance of individuals (such as health care providers, administrators, and leaders) and organizations (the entire workforce, policies and procedures, etc.). Research<sup>22</sup> shows that these indicators should be:
  - ✓ Clear, evidence-based, and standardized.
  - ✓ Embedded in performance management systems, 360 evaluations, and other assessment tools.
- c. Develop and implement a strategy to collect, manage and analyze data about anti-Indigenous racism and cultural safety. Based on the evidence,<sup>23</sup> the strategy should specify:
  - ✓ Data collection tools (e.g., organizational assessment)
  - ✓ Protocols for the ethical collection, analysis, use, and dissemination of data, including data ownership and sovereignty.
  - ✓ Protocols for the safe and respectful self-identification of Indigenous people. These protocols must be consistent with existing Indigenous research ethics frameworks (e.g., OCAP™, Chapter 9 of the TCPS-2, and Principles of Ethical Métis Research.<sup>24</sup>)
  - ✓ Roles and responsibilities for individuals working with data, including their obligation to respond to data that documents harm.

#### • PROMISING PRACTICES:

- Proposed BC-wide measurement framework for cultural safety and humility
- First Nations Health Authority complaints tracking
- Interior Health cultural safety and humility complaint system
- PHSA Indigenous Health’s Indigenous Cultural Safety Assessment Tool
- Winnipeg Regional Health Authority Framework for Action: Cultural Proficiency and Diversity
- The Annual Report on Equity in Healthcare Quality (or “Disparities Dashboard”) at Massachusetts General Hospital
- Brighton Center data management system to track racial outcomes, presented in “Race-Explicit Strategies for Workforce Equity in Healthcare and IT”
- National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) Cultural Safety Framework

## CHALLENGE: ORGANIZATIONAL RACISM

### 1. Ensure that the organization is a safe, supportive, and welcoming place for Indigenous staff and leadership.

- a. Promote the hiring, recruitment, and retention of Indigenous people at all levels of the organization.
- b. Institute evidence-based, wise practices<sup>25</sup> which include:
  - ✓ Implementing strategic, specialized programs that ensure selective recruitment and preferential hiring of Indigenous employees.
  - ✓ Examining hiring practices, criteria, and staff to determine whether they are biased against Indigenous people.
  - ✓ Providing cultural safety and anti-racism training for all Human Resources staff.
  - ✓ Ensuring accountability mechanisms are in place to prevent tokenistic or symbolic representation of Indigenous staff.
  - ✓ Offering cultural support, professional training and mentorship opportunities, to enable Indigenous employees to thrive in the workplace.

#### • PROMISING PRACTICES:

- “Listening days” in the HR department, presented in Bringing Reconciliation to Healthcare in Canada: Wise Practices for Healthcare Leaders

## CHALLENGE: SYSTEMIC RACISM

**Anti-Indigenous racism encoded within institutions that influence health care / Power is structured in ways that maintain settler dominance**

### > RECOMMENDATIONS

#### 1. Support initiatives in other sectors that also are focused on interrupting anti- Indigenous racism and discrimination.

- a. Healthcare workers must pay attention to, interact with, and influence workers in other sectors (e.g. justice, housing, education). They should:
  - ✓ Remain current with changes that are happening in other sectors that have an impact, direct or indirect, on Indigenous people who access services (e.g., June 2019 changes to federal child welfare policy).
  - ✓ Read and actively respond to calls to action identified in major reports about Indigenous people and those by Indigenous-led organizations (e.g., MMIWG Final Report Calls to Justice, the Calls to Action outlined in the Report of the TRC of Canada).
  - ✓ Learn from – and practice – successful strategies from other sectors.
  - ✓ Advocate for change in other sectors by building coalitions and partnerships; supporting projects that promote collaboration; and participating in political processes that bring positive change to policies and systems.

## APPENDIX A: CREDITS

### PRIMARY AUTHORS

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### ACKNOWLEDGEMENTS FOR THINK TANK EVENT

The Think Tank would have not been possible without the participation and generosity of the 35 leaders who attended the gathering. We thank you for your time and lasting commitment to this work. We would also like to extend our deep gratitude to Elders Gerry Olemen and Lillian Howard; graphic recorder Sam Bradd; presenters Jane Collins, Dr. Barry Lavallee, Dr. Collin van Uchelen, Sally Maguet, Leslie Varley, Tanya Davoren, and Harmony Johnson; San'yas facilitators Dawn Tisdale, Richard Bull, Chelsey Branch, Maria Gomes, Manjit Chand, and all of those who were involved in the planning and coordination of the Think Tank, including Christine Ho-Miller and Anne Cochran. Indigenous Health at PHSA sponsored the event.



# APPENDIX B: ABOUT THE THINK TANK

## CONTEXT

The province of British Columbia is in the midst of a movement towards cultural safety and humility in health services.<sup>26</sup> This movement is the culmination of generations of Indigenous activism in the area of health care (e.g., 1970 Red Paper<sup>27</sup>, 1996 Royal Commission on Aboriginal Peoples<sup>28</sup>) and follows the signing of the Transformative Change Accord: First Nations Health Plan<sup>29</sup> in 2005. The Accord laid the groundwork for a series of agreements and commitments that emerged in the past decade, including:

- The British Columbia Tripartite Framework Agreement on First Nations Health Governance<sup>30</sup>
- The Declaration of Commitment to Cultural Safety and Humility for First Nations and Aboriginal People in British Columbia<sup>31</sup> (signed by all six regional health authorities in British Columbia)
- The Letters of Understanding with Interior Health, Island Health, and Fraser Health regarding culturally-appropriate care and services for Métis
- The 2017 British Columbia Ministry of Health Mandate Letter<sup>32</sup>
- The Truth and Reconciliation Commission of Canada's Final Report<sup>33</sup> and Calls to Action<sup>34</sup>
- The United Nations Declaration on the Rights of Indigenous Peoples<sup>35</sup>

Despite this promising landscape, health leaders agree there is still much work to be done to improve the experiences and safety of Indigenous patients and staff within the health care system.<sup>1</sup> Anecdotal, organizational, and peer-reviewed information confirms that anti-Indigenous racism is pervasive, and that Indigenous people continue to experience harm (see **Anti-Indigenous Racism within the Health Care System: A Literature Review**). The Think Tank gathering was organized in response to these disturbing trends.

## OBJECTIVES

The objectives of the Think Tank were to:

- Initiate ongoing cross-system collaboration to address racism and disrupt harm to Indigenous people in the health care system.
- Co-create a cross-system framework as well as interventions to address anti-Indigenous racism both within the PHSA and organizations province-wide.



Graphic recording by Sam Bradd | Drawing Change of the opening, welcome, and San'yas data presentation

3 larger details of the graphic are included on the following pages.

## OBJECTIVES

- INITIATE ONGOING, CROSS SYSTEM COLLABORATION TO ADDRESS RACISM AND DISRUPT HARM TO INDIGENOUS PEOPLE IN THE HEALTH CARE SYSTEM
- CO-CREATING A CROSS-SYSTEM FRAMEWORK

“How do I TELL this to YOU - so you FEEL GOOD?”



Dr Emma Laroque

You have a **ROLE** in transforming THE SYSTEM

SINCE WE STARTED... NOTHING has CHANGED.

WE NEED a SYSTEMIC SHIFT.

there's NO ONE ELSE. IT'S US.

all meetings are transformations  
WHAT BRINGS YOU  
HERE

~ KWAKWAKA'WAKW

## CATEGORIES OF HARM



DEATH



PROLONGED PAIN/SUFFERING



MEDICAL COMPLICATIONS



FAMILY + COMMUNITY DISRUPTION



RELUCTANCE TO/ DELAY/ REFUSAL OF CARE



LOSS OF AUTONOMY



EMOTIONAL/ PSYCHOLOGICAL/ EMOTIONAL HARM



UNDEFINED

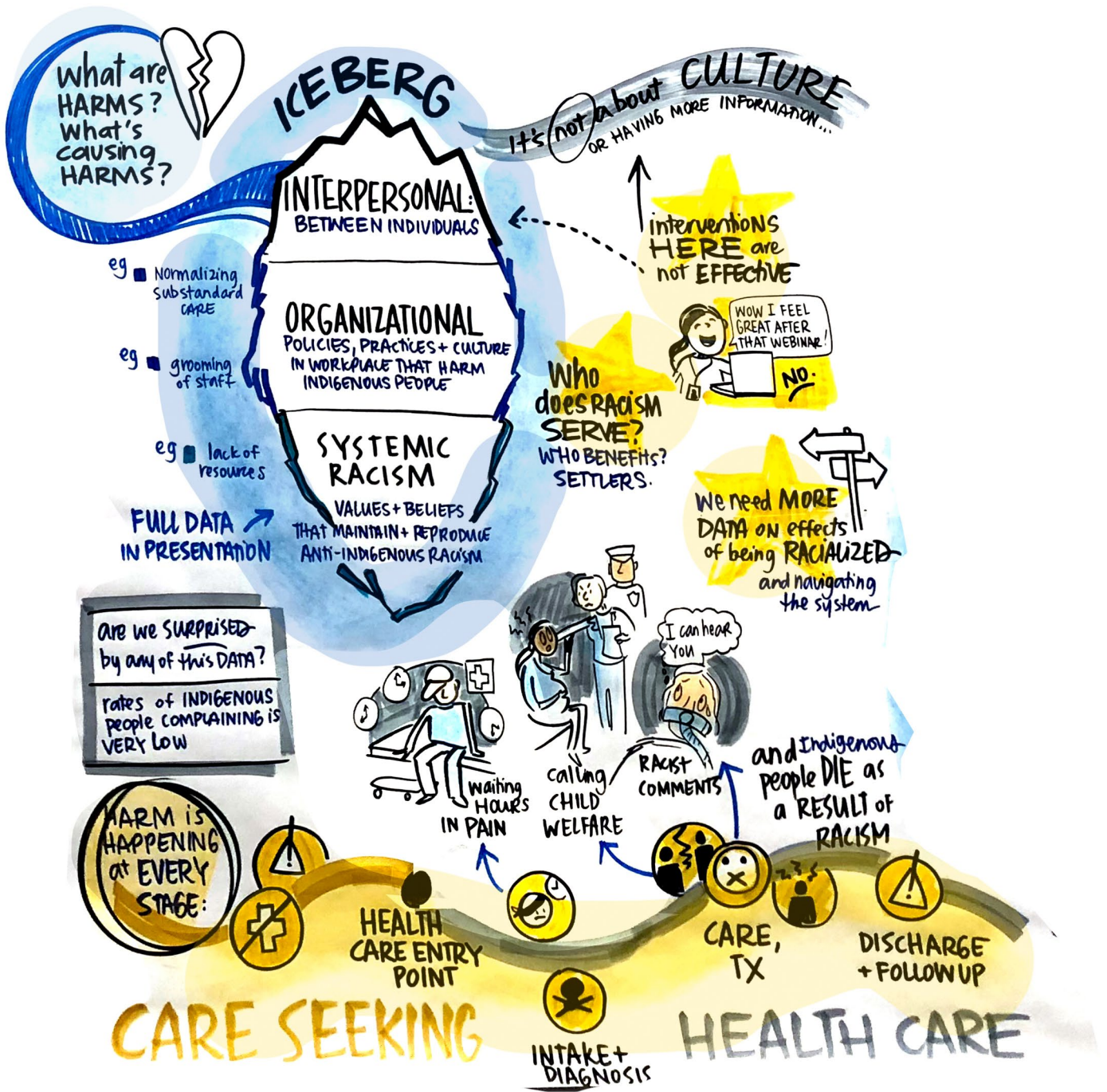


SAN'YAS DATA

- REVIEWED 1120 ENTRIES
- KEYWORD SEARCH
- and making SENSE of the DATA



Graphic recording by Sam Bradd | Drawing Change of the opening, welcome, and San'yas data presentation: panel 1



Graphic recording by Sam Bradd | Drawing Change of the opening, welcome, and San'yas data presentation: panel 2











Graphic recording by Sam Bradd | Drawing Change of the opening, welcome, and San'yas data presentation: panel 3



# APPENDIX C: MAPPING THE HARMS OF ANTI-INDIGENOUS RACISM IN THE BC HEALTH CARE SYSTEM

An experienced, inter-racial research team at PHSA used an anti-racist, critical lens to analyze data that revealed the harms occurring to Indigenous people within the BC health care system. The data was collected from discussion board posts and journal entries of participants who completed the health component of San'yas training in BC: 1,120 responses were reviewed and 252 met the inclusion criteria.

The research analysis revealed that the harm affecting Indigenous people falls into eight categories. They are listed in the box below and illustrated by the anecdotes that follow.

CATEGORIES OF HARM FROM SAN'YAS DATA			
	<b>Death</b>		<b>Reluctance, refusal or delay in accessing care</b>
	<b>Prolonged pain/suffering</b>		<b>Loss of autonomy</b>
	<b>Medical complications, e.g. condition worsened after being denied care</b>		<b>Emotional, psychological or spiritual, e.g. being traumatized by interactions with health care system; Indigenous practices undermined or misappropriated</b>
	<b>Family and/or community disruption, e.g. child apprehended</b>		<b>Wide-reaching or undefined harm, e.g., impact of racist behaviours either a) span multiple categories or b) are not documented, but are undeniable</b>

“

*Dismissive, incomplete assessments (at any point in an emergency encounter) have resulted in severe and sometimes deadly consequences for patients. **I have seen this happen in a straight line of dismissive ambulance crew, dismissive triage nurse, dismissive physician; leading to patient death from an inter-cranial event. I learned of three of these cases in mortality and morbidity rounds. Each involved an Indigenous male with long-standing alcohol abuse disorder.** It is well established that individuals with chronic alcoholism are at greater risk to sustain an inter-cranial hemorrhage from head trauma. This raises the uncomfortable question as to why these cases happen when all the risk factors are there and indicate the need for an urgent head CT?*

## Death



“

*An Indigenous teenager had fallen off his skateboard and broken his collar bone. The ambulance attendant wheeled him into the waiting room where **he sat for hours. In that time, not one clinical staff member came to see him.** My wife and I got him blankets, water, and offered coffee. We asked the nurse on duty if they could give him anything for his pain, as he was visibly shaking. The response was, “We will get to him when we get to him.” The White person I was with who was sitting right in front of the youngster was regularly seen and provided with updates, even though her condition was far less painful or critical.*

## Prolonged pain and suffering



“

*I was once asked to perform a cognitive assessment on an Indigenous client in the inpatient rehab unit where I was helping out. When I reviewed his chart, there were violence alerts throughout, due to one incident when he had threatened the life of a nurse in Emergency. He went on to explain that his initial interaction with this nurse was angry because **she sent him home without a diagnosis. He explained he continued to have symptoms of vertigo and was found on the floor by his family three hours after he was sent home from ER. Of course, the ambulance was called, and he had had an acute episode of a stroke.** He explained the initial nurse in ER never took his vitals, she just sent him home. Unfortunately, he continued to have the violence alert on his medical chart.*

### **Medical complications**



“

*Through a friend, I was made aware of an incident where a young Métis woman visited a hospital for a routine pregnancy check-up. The nurse read in her medical record that she was Métis, and saw a notation from years before about a child welfare issue, long since resolved. This made her immediately call in child welfare. My friend witnessed the distress of the pregnant woman and her interrogation at the hands of people who misunderstood her.*

### **Family and/or community disruption**



“

*I was with a young woman who **let her illness go untreated for a long time because of the discrimination she faced the previous times she went to hospital. She discussed the racial slurs she had experienced.** I am learning, through this teaching, that I did not do everything I could have, but she eloquently articulated how her care had been compromised due to her race.*

**Reluctance, refusal or delay in accessing care**



“

*A young infant became seriously ill and eventually was diagnosed with a condition that required an organ transplant, with a guarded prognosis even then. After much discussion with the family and community, the parents made the agonizing decision to provide palliative care for the infant, rather than putting him through questionable surgery in a city several provinces away from home. The specialist who had determined that a transplant was needed was unhappy with their decision and decided they were guilty of negligence. **He set in motion the process to apprehend this baby, stating that they were unfit parents who believed traditional medicine would heal their son. The parents were forced to go to another province to avoid the apprehension, then spent the few months remaining to them, fighting a court battle to remain with him, and care for him medically and spiritually.** At the same time, a patient of mine of European heritage had a baby with a similar prognosis. These parents were allowed to make the decision to palliate, with little opposition and much support from the local medical community. The difference in treatment that these two families received was incomprehensible to me at that time, but something I have seen too frequently since.*

**Loss of autonomy**



“

*An Aboriginal woman came in as a trauma victim who required extensive surgery that lasted most of the night. As we were giving her a post-op bath (**thinking she was still under anesthetic**) a racist remark was made at her bedside as we were busily doing our tasks at hand. She was on a ventilator and had a breathing tube in place. When I looked into her eyes a few moments after the remarks were made, she had tears. I was mortified and it was too late. The damage of those words was done.*

**Emotional, psychological, and spiritual harm**



“

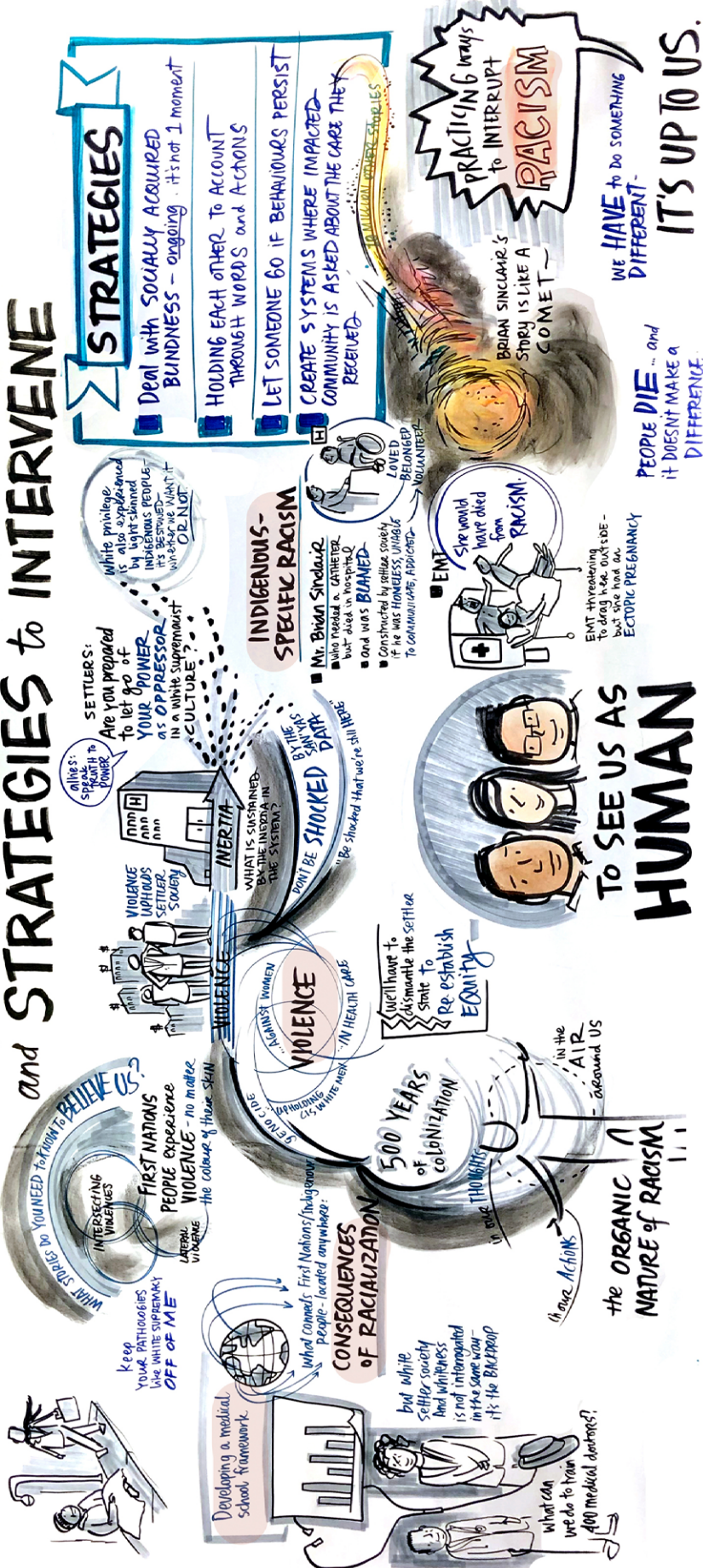
*Working with nurses, doctors and various administrators, I had to endure multiple negative comments about one remote community: **‘Oh that community is the dog’s breakfast!’ (from a senior rep in health); ‘Nobody wants to work in that community! It isn’t safe!’ ‘There are too many addicts nobody can work there alone!’** This in turn made it extremely difficult to recruit new providers to a community that desperately needed and wanted them. The accusations and stereotypes were unfounded and based on an incident that had occurred nearly 30 years ago.*

**Wide reaching or undefined harm**



DR BARRY LAVALLEE

# ANTI-INDIGENOUS RACISM and STRATEGIES to INTERVENE



# APPENDIX D: INDIGENOUS CULTURAL SAFETY ASSESSMENT

The ICSA tool offers PHSa employees an opportunity to reflect on their knowledge, awareness and skills in this crucial area. It helps to identify perceived barriers as well as potential gaps in knowledge and understanding. It also serves as a measure of staff commitment to, and enthusiasm for ICS.

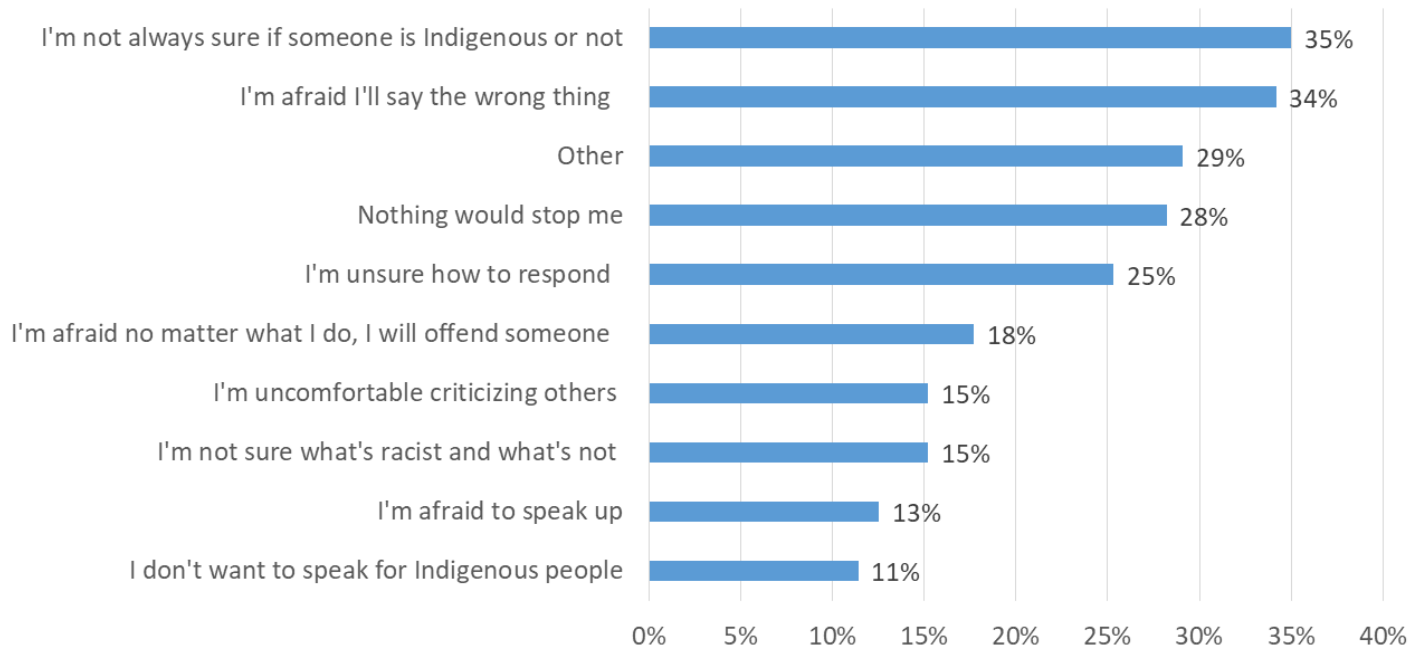
Since it was conceived in June 2018, the ICSA tool has been reviewed and revised several times with input from Indigenous and non-Indigenous scholars, educators, managers and senior executives. It has been beta tested by nearly 100 volunteers and is now in digital form and ready for the next stage of development and implementation.

Most questions are based on a six-point Likert rating scale (1 “not at all confident” to 6 “very confident.”) Other questions are open-ended, and some ask participants to select all statements that apply. Beta test responses show considerable variability in respondents’ confidence in the ability of their organizations to include Indigenous perspectives in planning and evaluation and to acknowledge employees for standing up to racism against Indigenous people.

How confident are you in your <i>organization</i> doing the following with 1 being not at all confident and 6 being very confident?	Not at all confident				Very confident		I don't know
	1	2	3	4	5	6	
Including Indigenous perspectives in planning and evaluation							
Supporting employees to respond to racism against Indigenous people							
Providing access to Indigenous Cultural Safety Training (e.g. <i>San'yas</i> )							
Supporting Indigenous employees							
Taking action in response to reports of racism against Indigenous people							
Acknowledging employees for standing up to racism against Indigenous people							
Modelling culturally-safe leadership (e.g. supporting staff to interrupt racism against Indigenous people)							
Working collaboratively with Indigenous communities or agencies							
Improving health services for Indigenous people							
Creating a work environment that is free of racism against Indigenous people							

In another section of the ICSA tool, participants are asked to identify the factors that might discourage them from acting against racism in the workplace, by selecting all the statements that apply. The top ten reasons for not taking action that emerged from the beta testing are presented in the graph below.

## Top Ten Reasons for Not Taking Action



## PROVINCIAL PERSPECTIVES

**Provincial participants in the Think Tank gave specific examples of actions their organizations are taking to effect change:**

**The BC Association of Aboriginal Friendship Centres (BCAAFC)** collaborated with the Community Legal Assistance Society to create and implement a training program to educate Indigenous people about their rights and the complaints mechanisms which should be in place to serve them. They are continuing to work toward: determining how to address complaints; identifying how to address poor-quality service; and helping Indigenous people to find and register their voices about the quality of the service they receive.

**Métis Nation British Columbia (MNBC)**, with the support of the PHSA and Ministry of Mental Health & Addictions, has been organizing gatherings that bring together Elders and youth to articulate Métis understandings of cultural wellness, and to enrich the emerging work around Métis cultural safety and humility. While organizations often emphasize the importance of nurturing relationships, they may not be as successful in forming them. Lateral violence between Indigenous organizations still needs to be addressed to ensure that collaboration is happening.

**The First Nations Health Authority (FNHA)** is developing cultural safety and humility standards as a foundation for its Indigenous Cancer Strategy. The FNHA also has committed to building a better complaints/incident reporting system and continues to work on: aligning anti-racism efforts; preventing individual/organizational goals from impeding mutual goals; supporting more forums like the Think Tank to create a shared understanding of the challenges and how to address them, and working together on accountability and reciprocal responsibility.



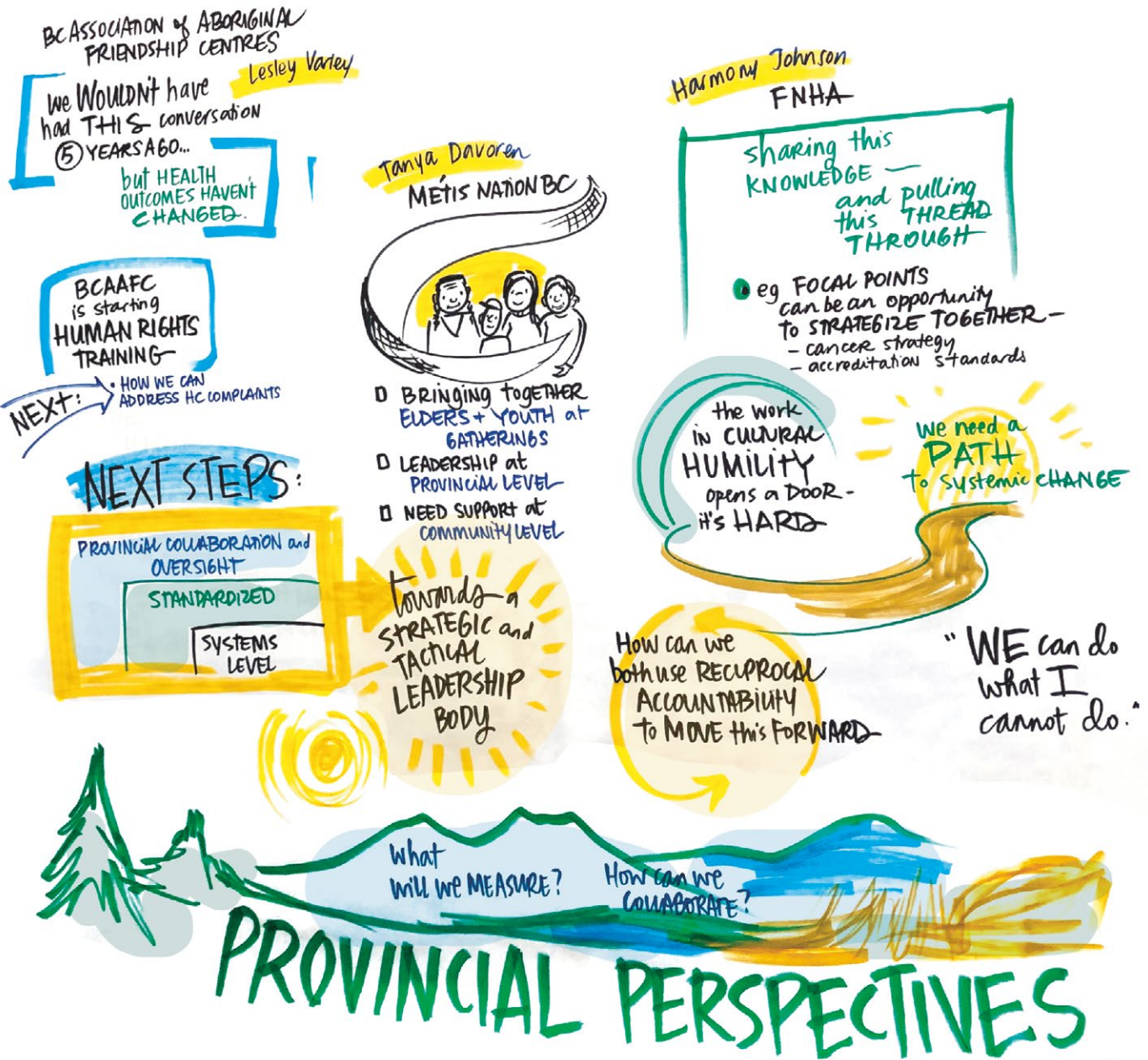


Figure 1. Graphic recording of provincial perspectives talk

## APPENDIX E: GLOSSARY

**Racism** has been defined as the aspects of Canadian society that “overtly and covertly attribute value and normality to White and Whiteness, and that devalue, stereotype, and label racialized communities as ‘other,’ different, less than, or render them invisible.”<sup>18 p.269</sup> Anti-Indigenous racism is racism that is specifically directed towards Indigenous people in Canada (i.e. individuals who self-identify as First Nations, Inuit, and/or Métis) which manifests at interpersonal, organizational and systemic levels. An Iceberg Model is often used to illustrate this.

**Interpersonal (or relational) racism** is the most obvious form of racism. It occurs when a person experiences discriminatory behaviour from those they encounter in day-to-day-life, ranging from name calling to racial slurs to assault or murder.<sup>36</sup> Interpersonal racism includes microaggressions, which are “brief and commonplace verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color.”<sup>37, p. 271</sup> Interpersonal racism is not always intentional, and not always direct. It could be a comment made behind someone’s back. Within the health care system, interpersonal racism can occur between health care providers and patients, front-facing staff (e.g. helpline operators) and community members, Indigenous and non-Indigenous staff, and health care policy-makers or administrators.

**Organizational racism** occurs when organizational policies, practices, and workplace cultures consistently penalize, disadvantage, or otherwise harm Indigenous people. Examples of anti- Indigenous racism at the organizational level include a lack of accountability for incidents of interpersonal racism (e.g., a lack of mechanisms to report incidents and no follow-up procedures); a workplace culture that normalizes stereotyping or racist remarks about Indigenous people; or policies that are not designed with Indigenous people in mind or are not enforced equally across racialized groups.<sup>38</sup>

**Systemic racism** (also referred to as structural or institutional racism) occurs when a dominant group is established and its power is reinforced through inequitable laws, policies, rules and regulations, and access to resources.<sup>39</sup> Systemic racism includes both actions and inactions. It maintains and perpetuates inequities between racialized groups and reflects distorted values and worldviews (e.g., the notion that Indigenous people and knowledge systems are inferior, conquered, and uncivilized, while White settler-imposed systems are superior, inevitable, and ideal). Examples of anti-Indigenous racism at the systemic level include the chronic underfunding of health services within rural and remote Indigenous communities; the exclusion of Indigenous content from settler-imposed elementary and secondary school curricula, and the exclusion or dismissal of Indigenous approaches to health and health care within the mainstream health care system. This last example can also be interpreted as a form of **epistemic racism**. Epistemic racism is the positioning of the knowledge of one racialized group as superior to another.<sup>40</sup>

BC ASSOCIATION of ABORIGINAL FRIENDSHIP CENTRES  
Lesley Varley  
We WOULDN'T have had THIS conversation 5 YEARS AGO...  
but HEALTH OUTCOMES HAVEN'T CHANGED.

BCAFC is starting HUMAN RIGHTS TRAINING  
NEXT: HOW WE CAN ADDRESS HC COMPLAINTS

How can we both use RECIPROCAL ACCOUNTABILITY to MOVE THIS FORWARD

### **San'yas Indigenous Cultural Safety Program (San'yas)**

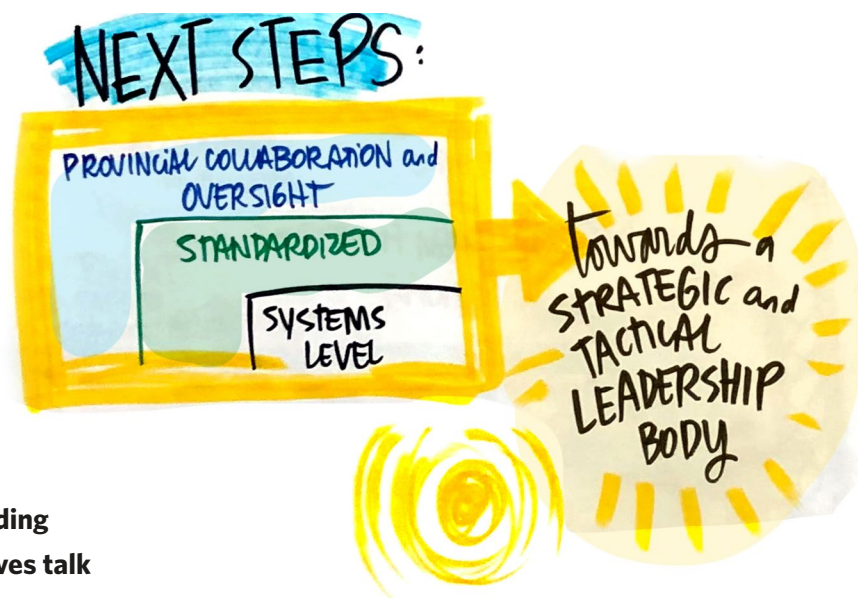
The San'yas Indigenous Cultural Safety Training Program (San'yas) offers a variety of online trainings designed to help participants eliminate anti-Indigenous racism and promote cultural safety when interacting with Indigenous people. Some content is directed at service providers and administrators (e.g., in health care, social services, child protection, and justice), while other content/courses are broader in scope and suitable for the general public. The training is led by highly qualified facilitators, and grounded in anti-racist pedagogy, transformative learning theory, and evidence-based teaching practices. San'yas training addresses colonization in Canada; racism, discrimination, and stereotyping; and approaches to taking action against racism in workplaces the in communities.

San'yas is housed within the Indigenous Health department at the Provincial Health Services Authority in Vancouver, British Columbia. More than 90,000 Canadians have completed a San'yas training course since its inception in 2009 (current to August 2019). British Columbia Health Authorities have funded training for thousands of participants. (PHSA - 6,656; Fraser Health - 3,687; Vancouver Coastal Health - 2,230; Interior Health - 4,468; Northern Health - 4,171; Island Health - 4,023; FNHA - 1,095.)

### **Tokenism**

Tokenism is defined as “the practice of doing something (such as hiring a person who belongs to a minority group) only to prevent criticism and give the appearance that people are being treated fairly.”<sup>41</sup>

Tokenism is often the result of organizations rushing to improve diversity and, in doing so, failing to genuinely include diverse people and ensure equity within the workplace.<sup>42</sup> The rush to hire Indigenous people in organizations across Canada is partially a result of the post-Truth and Reconciliation Commission (TRC) era, when people have felt compelled to do something to respond to the Calls to Action. However, it is harmful to hire people without implementing strong anti-racism initiatives organization wide. Tokenism is damaging because it asks Indigenous people to be present but does not give them the power or influence they need to make meaningful contributions or change. It also creates the illusion that an organizational is moving towards reconciliation, when it is not.



**Detail of graphic recording of provincial perspectives talk**

# APPENDIX F: LIST OF IDEAS SHARED DURING THINK TANK GATHERING

TABLE A-1. FULL LIST OF IDEAS FROM THE ACTIVITY 'FACTORS PERPETUATING ANTI-INDIGENOUS RACISM'.

THINK TANK FINDINGS: WHAT IS HOLDING THESE SYSTEMS IN PLACE?		
INTERPERSONAL	ORGANIZATIONAL	SYSTEMIC
<ul style="list-style-type: none"> <li>• Not challenging harmful beliefs</li> <li>• Following others/peer pressure</li> <li>• What about the “other” oppressed people?!</li> <li>• Excuses: that is what I know – how I was raised and trained</li> <li>• Maintain status quo for survival</li> <li>• Deny the problems/issues</li> <li>• Fear – of losing control of the other; mis-stepping</li> <li>• Fear of doing the wrong things</li> <li>• Lack of education</li> <li>• Acceptance of behaviour that is racist – senior leaders</li> <li>• Grooming of employees</li> <li>• Peers, family, media – all support views of Indigenous people</li> <li>• “People protect their own” ethnic groups</li> <li>• Keep people uninformed about how to address racism</li> <li>• Make it optional to address /identify racism</li> <li>• Blame individuals for their health crisis, social status, poverty level, behaviour</li> <li>• If criticism, make it about person/situation</li> <li>• Fear of social rebuke =&gt; privilege</li> </ul>	<ul style="list-style-type: none"> <li>• Ignore or deny harm</li> <li>• Get rid of anti-Indigenous racism experts</li> <li>• Tokenizing committees</li> <li>• Non-reflective workforce</li> <li>• Adversarial relationship normalized</li> <li>• Rigidity of policies and practices</li> <li>• Setting priorities without resources</li> <li>• Clinician privilege “Oh that’s just how Dr. X is... he is a great surgeon”</li> <li>• Multiculturalism and cultural sensitivity normalized in regulatory bodies</li> <li>• Present as performative but goal is not-performative</li> <li>• Discourse of support</li> <li>• Inaction</li> <li>• Maintain lateral violence and hierarchy</li> <li>• Maintain values and beliefs that are non-disruptive “stay positive”</li> <li>• Lack of Indigenous leadership</li> <li>• Competing priorities?</li> <li>• Ignoring the voices who experience harm</li> <li>• Getting people to lead organizational change who do not have the skills or knowledge to do so – so status quo is maintained</li> <li>• Tick box approaches</li> <li>• Racist leaders – hierarchy</li> <li>• Reliance on Indigenous people to address racism</li> <li>• Imposing solutions – no consultation or real engagement with Indigenous people</li> <li>• Indigenous people being set up to fail</li> <li>• Depending on Indigenous Health for all ideas, actions re: reconciliation</li> <li>• No accreditation standard</li> <li>• Don’t critically examine policies to see if they are racist</li> <li>• Uncertainty about how to change</li> </ul>	<ul style="list-style-type: none"> <li>• Denial of colonization</li> <li>• Education system rooted in racism (i.e. curriculum)</li> <li>• Enforcers of “rules” – police, courts, etc.</li> <li>• Resourcing capacity and time constraints</li> <li>• Justice system discrimination (judges not referring Aboriginal people to forensic psychiatrists, only to jail)</li> <li>• Keep nursing/health assessments that harm Indigenous People (displacement policy)</li> <li>• Media that is owned and represents racist perspectives (e.g. social media)</li> <li>• Ignoring Social Determinants of Health (SDOH) and upholding class system</li> <li>• NIMBY – not in my backyard – aura of superiority</li> <li>• Only funding the dominant society – not “those” people (small portion)</li> <li>• Ignore disconnect to the harm</li> <li>• Culture of expertise</li> <li>• Culture of superiority – old boys club</li> <li>• Invisibilization of Indigenous people – population data focus</li> <li>• Belief that Canada is a good and just society</li> <li>• Eurocentric/Western/colonial knowledge dominates</li> <li>• Development/revision of policy</li> <li>• Economic drivers – blocking pipelines, blaming Indigenous people</li> </ul>

TABLE A-1 CONT'D

THINK TANK FINDINGS: WHAT IS HOLDING THESE SYSTEMS IN PLACE?		
INTERPERSONAL	ORGANIZATIONAL	SYSTEMIC
<ul style="list-style-type: none"> <li>• Maintain the belief that racist issues are not relevant to my work (b/c I don't see how it pertains)</li> <li>• Maintain the lie that we are "nice" people</li> <li>• Hold onto dominant worldviews</li> <li>• Ignorance</li> <li>• Fear of loss of control/wealth</li> <li>• White Canadians taking care of their own</li> <li>• Viewing sharing power as a loss</li> <li>• Permission not to know</li> <li>• Denial of the truth</li> <li>• Profound ignorance of the truth</li> <li>• Indigenous people get placed within roles =&gt; stereotypes, "dumb," patronizing, "angry," "disruptive"</li> <li>• Role of someone who is tasked with institutionalizing the harms</li> </ul>	<ul style="list-style-type: none"> <li>• Insulate leadership from knowing</li> <li>• Planning/politics are on 3,4,5 year cycles; no long term</li> <li>• Move people to other parts of the health system instead of addressing the problem</li> <li>• Really hard to make change – positive reinforcement for inertia</li> <li>• Keep cultural safety separate from patient safety</li> <li>• Protect your organization from criticism</li> <li>• Assessment of leaders/development based on White "color blind" criteria</li> <li>• Don't adjust standards of practice to respect culture</li> <li>• Lack of education</li> <li>• Organizational behaviour/culture that does not align with formal policies</li> <li>• Rigid institutions</li> <li>• No action taken on reports of racism</li> <li>• No accountability for racist practices</li> <li>• Not respecting the number of asks of Indigenous leaders/communities</li> <li>• Not making training mandatory</li> <li>• Leadership not addressing organization change</li> <li>• No organizational mandate for change</li> <li>• No budget</li> <li>• Do not hold people accountable for racism</li> <li>• No legal framework</li> <li>• Leadership not addressing organization change</li> <li>• Sticking to a pattern – comfortable; uncomfortable with change</li> <li>• Within 30 days general stereotypes are picked up. New immigrants "stay away from Indigenous people"</li> <li>• Policies, guidelines people can hide behind; become norms; "triage this way"</li> <li>• Silence</li> <li>• Race gets "coded" in guidelines; rationalized</li> <li>• Abdicating work - expectation is that Indigenous people will do the work</li> </ul>	<ul style="list-style-type: none"> <li>• Denial of colonization, racism in legislation; injustice; oppression</li> <li>• Difficulty of change – powerful people want systems in place</li> <li>• Legislation – Indian Act; messaging – needs to be managed</li> <li>• Patriarchy</li> <li>• Don't measure racism</li> <li>• Standard is White-centric</li> <li>• Employment laws that support or protect racism</li> <li>• Don't focus on children/youth to learn the truth</li> <li>• Continue to believe "quality" – same care for all [organizational]</li> <li>• Support a system where no one is to blame [organizational]</li> <li>• Focus on "residential schools" – not system</li> <li>• Media perpetuating stereotypes</li> <li>• Pass distorted views to the next generation</li> <li>• No moral compass</li> <li>• No political will</li> <li>• Distorted world view based on lies and illusions</li> <li>• Maintain control of lands and resources</li> <li>• Maintain individualistic political systems (Crossover with White dominance)</li> <li>• Maintain White dominance</li> <li>• Early years – imprinted beliefs =&gt; norms</li> <li>• Fear of litigation is an excuse</li> <li>• Long standing anti-Indigenous racism; schools and media legislation – other systems; normal and okay; "way it is"</li> <li>• Perpetuates myth that Indigenous people go "over there" – parallel services</li> </ul>

# APPENDIX F: LIST OF IDEAS SHARED DURING THINK TANK GATHERING, cont'd

TABLE B-1. FULL LIST OF IDEAS FROM THE ACTIVITY ‘DISMANTLING ANTI-INDIGENOUS RACISM’

THINK TANK FINDINGS: HOW CAN WE DISMANTLE THE SYSTEM?	
<ul style="list-style-type: none"> <li>• Need to understand the why to get to the how</li> <li>• Name racism and expanding conversation to be more explicit</li> <li>• Tackle racist legislations and policies (e.g. Indian Act – must also consider who is privileged within this Act, child welfare legislation, funding legislation)</li> <li>• Mitigate fear (when we are trying to bring about change, it can create fear about job loss; can enable racist policies)</li> <li>• Involve every area of the health care system – it is not just direct service providers but administrators and educators/trainers; taking ownership as leaders re: what we can do individually and collectively</li> <li>• Use a patient-centered focus and consider whose needs are being met</li> <li>• Harm reduction approach</li> <li>• Take up all the TRC Calls to Action (can’t cherry pick because overlapping) and acknowledge the truth before doing the reconciliation (many organizations lag in this regard)</li> <li>• More options for collaboration at government level</li> <li>• Personal growth and development</li> <li>• Engage multiple stakeholders</li> <li>• Outreach/collaborate with other systems</li> <li>• Focus =&gt; status quo: Who or what is complicit in prolonging the harms?</li> <li>• More education with audit</li> <li>• Working group across PHSA</li> <li>• Strengthening workplace conditions with structure</li> <li>• ICS San’yas mandatory</li> <li>• ICS Monitoring Framework</li> <li>• Creating space for dialogue and priorities</li> <li>• Recruitment screening to meet vision</li> <li>• Marketing anti-racism in a de-stigmatizing way</li> <li>• ELT-level prioritization</li> <li>• More accountability across systems</li> <li>• Long-term planning</li> <li>• Accountability structures with zero tolerance for racism</li> <li>• Multiple think tanks</li> <li>• Distributed ownership</li> <li>• Create channels</li> <li>• Bringing in other voices in the room; all inclusive voices to room and table</li> <li>• Become comfortable with discomfort</li> <li>• Action: resources, funds</li> </ul>	<ul style="list-style-type: none"> <li>• Indigenous engagement (e.g. advisory committees) all the way along</li> <li>• Build accreditation of culturally-safe services and organizations</li> <li>• Create safe and fair complaint process (E.g. Indigenous Patient Navigators could receive complaints)</li> <li>• Retraining and reconditioning of mindset of people working in the system from acceptance to change</li> <li>• Financial incentives or penalties (carrots and sticks) – motivate changes</li> <li>• Auditing and policing</li> <li>• Consider how we are measuring and reporting on this work</li> <li>• Repeal Indian Act; new Act on partnership and shared resources</li> <li>• Engaging community and co-creation of systems, e.g. complaints; ensure organizations have ability to provide culturally-safe care - How can community be engaged in this process?; investing resources for engagement/co- creation</li> <li>• Creation of safe spaces and organizations</li> <li>• Resourcing: Invest the resources to do this well; don’t set up programs not to be successful due to inadequate resourcing</li> <li>• Strategies about how to “act” (not just awareness)</li> <li>• Better ways of measuring and using data: Collecting data on experience of complaints; Not just submitting provider evaluations after grades go in (as is done in university) – evaluating after care experiences</li> <li>• Setting cultural safety hiring standards. E.g. interviewing processes – what questions are we allowed to ask? Questions could be embedded in existing interview guides</li> <li>• Setting practice standards for cultural safety and humility. Give clear examples of what good behaviours look like – not just concepts. Give opportunities to practice good behaviours)</li> <li>• Shift what is valued re: accountability. Currently the technical expert clinician who gets good patient outcomes but is verbally abusive is tolerated; patient outcomes need to be more broadly defined. Perhaps expand to health and wellness experience within system</li> <li>• Ensuring cultural safety is embedded in training curriculum</li> <li>• Acknowledge that racism is a problem in the system. More leaders standing up and acknowledging racism exists and cultural safety is needed</li> </ul>

TABLE B-1 CONT'D

THINK TANK FINDINGS: HOW CAN WE DISMANTLE THE SYSTEM?	
<ul style="list-style-type: none"> <li>• Focus on truth, past and present, in Truth and Reconciliation</li> <li>• Commitment to address anti-Indigenous racism</li> <li>• Moving from asking the Indigenous voice to make the change</li> <li>• Create culture of lateral kindness and really concretizing that in all of our interactions</li> <li>• Settlers taking responsibility, approaches that make people feel uncomfortable</li> <li>• Social justice, equity, critical theory language and approaches to writing policy. How to do policy needs to be more effective rather than just a check-box approach</li> <li>• Normalize Indigenous culture (not just in health care but other institutions as well, e.g. Maori haggas in schools) – valuing Indigenous knowledge and ways of knowing</li> <li>• Bringing kindness, justice, empathy into Canadian values</li> <li>• Dismantling the system – Presenting alternatives; idea of dismantling system can create anxiety and questions re: what are you going to replace it with? Also being careful about language around dismantling – service delivery needs to continue everyday</li> <li>• Address individual behaviours – accountability – zero tolerance for racist behaviours; address behaviours in a timely way</li> <li>• Embed changes in curriculum in primary education through university</li> <li>• Embed changes in performance management – here for anti-Indigenous competency</li> <li>• Policies to back change - not dependent on personality or role</li> <li>• Maintain energy and focus: have energy for this work and support each other</li> <li>• Explore synergies in this work; figure out how to align things from strategy through to policies. Racism is one factor of many – mental health of workers must be supported</li> <li>• Call it out! People need to know there is a racism problem in our system</li> <li>• Look at governing bodies to support. For Indigenous governing bodies, focus on how to engage community in a meaningful way.</li> <li>• Establish Sān'yas as the universal standard</li> </ul>	<ul style="list-style-type: none"> <li>• Increased sense of safety around reporting and complaints processes. Important to consider who runs it, where ownership sits, should it be independent, external. Need for racism and discrimination categories</li> <li>• Sān'yas should be a minimum standard requirement for everyone working in the healthcare system. It shouldn't be considered a tick box/one off; framed as continuing journey. Need to work with post-secondary institutions to meld curricula</li> <li>• Annual reviews or 360 evaluations (place for cultural safety and humility to fit in)</li> <li>• Safe ways for people to self-identify</li> <li>• Evaluate our providers after care ended</li> <li>• Engage leaders/leadership in conversations</li> <li>• Identify key decision makers and find ways to connect with them – true relationships</li> <li>• Learn and share knowledge – what has been successful?</li> <li>• Create mechanisms of sharing with each other and integrate into their own context – perhaps a place people can go to look for knowledge</li> <li>• Engage with patients and families</li> <li>• Create policies and be very specific about the types of things that are inappropriate and need to be reported and followed up on</li> <li>• Create this sense of crisis and urgency so that something actually happens</li> <li>• Have some successful evaluations and case studies</li> <li>• Create space for dialogue. We are all leaders, we are all here to effect change. Change doesn't matter if in line up at grocery store or in our offices. We are consumers of knowledge and have a responsibility to share, to normalize conversation. Shouldn't be one day to talk about racism and one space. We need to be open about it always.</li> <li>• Normalize the conversation – mobilize what we have talked about and the responsibility to do something about it</li> <li>• The Cheryl method – the think tank, the organizational assessment tool – these are novel and need to be used across the province and multiple sectors.</li> </ul>

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**Sanyas**

Indigenous Cultural Safety

Knowledge • Awareness • Action

