

**APPROACHES TO WORKING WITH ABORIGINAL ADULTS WITH ACQUIRED  
BRAIN INJURY: EXPLORING PERSPECTIVES OF SPEECH-LANGUAGE  
PATHOLOGISTS**

by

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## **Abstract**

Efforts to raise awareness of culturally safe speech-language pathology services for Aboriginal populations have grown in recent years. However, while most of the literature focuses on Aboriginal children and families, few studies are tailored towards the adult population. Furthermore, little is known in Canada or internationally about approaches to providing culturally safe care to Aboriginal adults with acquired brain injury in a speech-language pathology context.

The purpose of this qualitative study is to explore perspectives of speech-language pathologists working with Aboriginal adults with acquired brain injury (ABI) to develop an understanding of the supports, barriers, and facilitators in working with this population. Semi-structured, participant-driven interviews were conducted with seven speech-language pathologists from different geographical locations and health care settings across British Columbia. The data were interpreted using a method called thematic analysis to identify common topics and themes. A wide range of participant perspectives highlighted the diversity in participants' experiences.

A total of four topics were identified: (1) a description of service delivery for adults in British Columbia revealing various barriers and facilitators; (2) working with patients and families within the context of service delivery; (3) participants' concerns that they considered to be specific to Aboriginal peoples; and (4) participants' perspectives on cultural safety. Seven themes that reflect participants' personal statements emerged from the second, third, and fourth topic: building relationships with patients; family and community support; Aboriginal languages, culture, and identity; awareness of the impacts of colonization in health care; move towards holistic practice; participants' feelings of uncertainty; and role of building relationships in the

provision of culturally safe care. This study shows the need for broader research to develop a deeper understanding and explore Aboriginal views on cultural safety in speech-language pathology practice with Aboriginal peoples with ABI. It is also critical for clinicians to become culturally competent through continuing education in order to increase their ability to provide culturally safe care.

## **Preface**

The topic and qualitative design of this research study were developed by the author, Colleen Leung, and her thesis supervisor, Dr. Barbara Purves and thesis committee member, Dr. Barbara May Bernhardt. With guidance from Dr. Purves and Dr. Bernhardt, Ms. Leung was responsible for all data collection and data analysis. Ethics approval for this study was acquired from Interior Health Research Ethics Board (REB) through the British Columbia Ethics Harmonization Initiative and was also reviewed and approved by the Health Research Ethics Board (HREB) of Island Health, University of British Columbia (UBC) – Providence Health Care, and Northern Health under certificate number 2014-15-055-H. As permitted under the “BC Research Ethics Review Reciprocity Agreement,” this study was considered approved for the purposes of ethical review at UBC. Therefore, a separate certificate approval from UBC was not issued. Additional operational approval was received from all health authorities.

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## Chapter 1: Introduction

In recent years, efforts towards raising awareness of adapting services to Aboriginal<sup>1</sup> populations in order to provide broader and culturally safe services have grown. Speech-Language & Audiology Canada (Speech-Language & Audiology Canada, n.d.), a national organization supporting and representing speech-language pathology and audiology professionals in Canada, has completed several initiatives to provide information for clinicians regarding speech-language pathology and audiology services to First Nations, Inuit, and Métis residents in Canada. Two special issues focusing on service delivery for Aboriginal populations were published in the Canadian Journal of Speech-Language Pathology and Audiology (CJSLPA; Bressmann, 2011; Fitzpatrick, 2014). However, the featured studies primarily focused on working with children and families; no articles were specifically geared towards the adult population and little is known either in Canada or internationally regarding approaches to working with Aboriginal clients with acquired brain injury (ABI; Hersh, Armstrong, & Bourke, 2014a; Hersh, Armstrong, Panak, & Coombes, 2014b; Keightley et al., 2009; Keightley et al., 2011a; Keightley et al., 2011b; McLellan, McCann, Worrall, & Harwood, 2014). This lack of research raises concern and the need for further investigation, especially because Aboriginal populations are at greater risk of stroke and other conditions causing ABI compared with non-Aboriginal populations (British Columbia. Provincial Health Officer, 2009; Northern Brain Injury Association, n.d.).

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<sup>1</sup> When referring to the First Peoples of Canada, I use the term, *Aboriginal*, to include First Nations, Inuit, and Métis residents in Canada, unless otherwise specified. See Section 1.1 for more information on the use of Aboriginal terminology.

Acquired brain injury is a broad term used to define damage to the brain that occurs after birth and is unrelated to congenital brain impairment (Chapey, 2008). This includes, but is not limited to, traumatic brain injury (TBI) and cerebrovascular accident. Traumatic brain injury refers to brain damage caused by external forces causing displacement of the brain inside the skull, e.g., from penetrating objects, blunt blows to the head, motor vehicle accidents, or falls (Chapey, 2008). Cerebrovascular accident, or stroke, is the most common cause of aphasia and occurs when blood flow in the brain is interrupted by rupturing of an artery or by a blockage of a blood vessel or artery (Chapey, 2008). The rate for brain injury among the First Nations population is estimated to be approximately four to five times higher than the general population, with the rate reported to be higher in more remote locations (Northern Brain Injury Association, n.d.). Further, the 2007 British Columbia's Ministry of Health annual report on the health and well-being on Aboriginal people (British Columbia. Provincial Health Officer, 2009) states that over 11,000 Status Indians<sup>2</sup> were living with hypertension, an important risk factor for stroke. In comparison with other residents in British Columbia, the report states that the age-standardized incidence rate of stroke was much higher for Status Indians and the prevalence rate of stroke among Status Indians was 70% higher.

Research has also shown that ethnic and minority status are related to certain socioeconomic and environmental factors that may increase the risk of TBI, such as poverty, working in demanding and unsafe settings, restricted opportunities, and living in dangerous environments (Niemeir & Arango-Lasprilla, 2007). Aboriginal status appears to be negatively

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<sup>2</sup> I have made an effort to use the same terminology the authors have used in their research. See Section 1.1 for more information on the use of Aboriginal terminology.

correlated to recovery, with poorer outcomes for Aboriginal people possibly attributable to fewer formal and informal supports, such as professional translators or the loss of social support when a patient relocates away from their home community (Keightley et al., 2009).

Through perspectives of health care professionals or Aboriginal clients with ABI themselves, researchers from different geographical locations have conducted studies to begin addressing issues surrounding working with Aboriginal clients with ABI and their experiences with the health care system. Working with the Aboriginal population requires culturally competent skills including acknowledgement of cultural and linguistic diversity, as well as knowledge of the colonial history and recognition of its implications in order to understand the socio-political realities Aboriginal people face today (Provincial Health Services Authority [PHSA], n.d.). Accordingly, the likelihood that many Aboriginal peoples may hold different views of health and trust in western health services is one concept that health providers also need to take into consideration. Qualitative research studies from northwestern Ontario have provided one of the first stepping-stones in Canadian research exploring rehabilitation challenges for Aboriginal clients recovering from ABI from perspectives of a cultural coordinator, mental health care workers, elders, and traditional healers (Keightley et al., 2011b) and perspectives of Aboriginal clients with ABI and health care professionals (Keightley et al., 2009, 2011a); however, speech-language pathologists were not included. Further research studies from Australia (e.g., Hersh et al., 2014a) and New Zealand (e.g., McLellan et al., 2014) have narrowed this topic to speech-language pathology, focusing on the experiences of speech-language pathologists and of Aboriginal people with acquired brain injuries and their families.

Taken together, these studies from Australia, New Zealand, and northwestern Ontario, Canada, as further discussed in section 1.8, show that while there are similarities across the

research findings, there are also important differences that highlight the need to consider services for Aboriginal peoples within specific contexts. Because no research has been conducted in British Columbia concerning service delivery to Aboriginal adults with acquired communication disorders, it may not be appropriate to generalize current research literature from different geographical locations to Aboriginal peoples living in British Columbia. Thus, it is critical to also explore barriers and facilitators in working with Aboriginal peoples with ABI in British Columbia to gain a deeper insight into providing culturally safe speech-language pathology services in this province.

Therefore, the current qualitative study set out to explore perspectives of speech-language pathologists from different geographical locations, health care settings, and health authorities in British Columbia who have experience working with Aboriginal adults with ABI. The following sections in this chapter provide context specific to British Columbia that uncovers the province's historical background of colonization and assimilation and current issues faced in Aboriginal communities and health care, differentiating this province from other geographical locations. First and foremost, usage of terminology related to Aboriginal peoples will be clarified. In addition, a description of my background as a researcher is provided for readers, explaining my personal motivation and rationale in pursuing this research project. Historical and current issues, such as endangered languages and dialects in Aboriginal communities, Indian hospitals, and the health disparities and inequalities manifested from colonization and assimilation will be explored. Finally, research that investigated approaches to working with Aboriginal adults with ABI from Australia, New Zealand, and northwestern Ontario, Canada will be discussed further.

## 1.1 Aboriginal Terminology

Many terms are used to refer to the First Peoples of Canada, i.e., a group of people who can trace their ancestry prior to the arrival of Europeans and Americans in the late 18<sup>th</sup> century; these terms include *Indians*, *Indian bands*, *Natives*, *Aboriginal peoples*, and *Indigenous peoples*. According to the Canadian Constitution, the term *Indigenous peoples* refers to Aboriginal people and includes First Nations, Inuit, and Métis (PHSA, n.d.). Accordingly, *Indigenous* refers to individuals or groups who share and maintain the traditional, cultural, and spiritual understandings and worldviews of their ancestors (PHSA, n.d.).

The term *First Nations* replaced the term *Indian* (PHSA, n.d.), and, while there are Inuit and Métis individuals that live in British Columbia, First Nations is most commonly used in British Columbia (Muckle, 2014). The term First Nations alleviates derogatory and primitive connotations that can be associated with other terms, corrects the inaccurate label originally used by Christopher Columbus, and recognizes that the First Nations peoples' ancestors were in regions before the Europeans (Muckle, 2014). Two broad categories of First Nations peoples live in British Columbia: registered (i.e., status) and non-status Indians (Muckle 2014; PHSA, n.d.). The terms *Aboriginal* and *band* have specific legal meaning, and *Indian* continues to be used to define legal terms by the provincial and federal governments as described in the Canadian Constitution and Indian Act (Muckle, 2014; PHSA, n.d.).

Throughout this study, I have made an effort to use the same terminology used by the author whose research I reviewed. When referring to the First Peoples of Canada, I use the term *Aboriginal* to include First Nations, Inuit, and Métis residents in Canada, unless otherwise specified.

## **1.2 Situating the Researcher in Research**

Prior to pursuing my master's degree in speech-language pathology, my position as a research assistant at the UBC First Nations and Endangered Languages Program (formerly known as the First Nations Languages Program; First Nations and Endangered Languages Program, n.d.) piqued my interest in working with Aboriginal communities on language documentation and revitalization. While working alongside a First Nations community located in northern British Columbia, I gained a deeper appreciation for community collaboration to understand the cultural and language needs in order to build trusting relationships and mutually develop community-based solutions.

The master's program at the UBC School of Audiology and Speech Sciences offers a unique course, "Approaches to Audiology and Speech-Language Pathology for people of First Nations, Métis, or Inuit Heritage" (School of Audiology and Speech Sciences, n.d.), which I completed in the first year of my coursework. Through the course, I had the opportunity to engage in community learning, develop culturally sensitive skills and strategies, and appreciate the inextricable nature of culture, language, and identity. In efforts to continue building on my previous research experience in working with Aboriginal communities and through literature review, I have discovered that there is a paucity of health research surrounding Aboriginal communities, especially in the field of speech-language pathology. As a result, I wish to pursue this emerging field and actively raise its profile for further research in speech-language pathology contexts. Furthermore, I have completed the Provincial Health Services Authority (PHSA) Indigenous Cultural Competency Online (ICC) Training Program (n.d.) in preparation for this research project.

### **1.3 Endangered Languages and First Nations English Dialects in British Columbia**

British Columbia is the province with the greatest linguistic diversity of Aboriginal languages and culture compared to other provinces in Canada. There are 203 First Nations communities and 34 unique First Nations languages in British Columbia, comprising approximately 60% of First Nations languages in Canada (First Peoples' Cultural Council [FPCC], 2014). However, British Columbia's First Nations languages are critically endangered (Ball & Bernhardt, 2008; FPCC, 2014).

The rapid decline and loss of First Nations languages is a result of the Canadian government's assimilation policies and the removal of children from their homes to residential schools forbidding them to speak their native language, as well as the social, industrial, and cultural pressures imposed by a dominant English-speaking society that excludes First Nations languages from government, commerce, industry, arts, education, and media (Ball & Bernhardt, 2008; FPCC, 2014). The First Peoples' Cultural Council's (2014) report on the status of British Columbia's First Nations languages states that although the number of fluent speakers is declining, there are more semi-fluent speakers since 2010: only 4.08% are fluent speakers and 9.32% are semi-fluent speakers. From the reported fluent speakers, 59% are aged 65 years or older; however, 88% of semi-fluent speakers are under 65 years old.

First Nations English dialects play a role in the overall status of First Nations languages in Canada. According to Ball & Bernhardt (2008), First Nations dialects reflect a conflicting interplay between language loss and language revitalization, in which the existence and use of First Nations dialects is "powerful evidence of the cultural hegemony of English and of the dominant culture's disruption of the intergenerational transmission of First Nations languages" (p. 575). Ball and Bernhardt's (2008) exploratory project described possible characteristics of

First Nations English dialects in the domains of phonology and phonetics, morphosyntax, lexical, and discourse. For example, phonology and phonetic features may include differences in rhythm, stress, tone, intonation, speech rate, and voice quality or differences in overall positioning of articulators. Morphosyntax characteristics may include distinctive usage of pronouns, tag questions, and conjunctions. Differences in vocabulary usage in First Nations children were also reported, such as a lack of spatial location or time marking terminology. Finally, discourse-related features may include differences in the use of silence, listening, eye contact behaviours, turn-taking, and topic development in narratives.

Currently, cultural and language revitalization efforts are being undertaken in many First Nations communities. First Nations dialects can play an important role in language revitalization initiatives and enhancement of Aboriginal identity through the ongoing transmission of Indigenous cultures. Ball and Bernhardt (2008) emphasize the importance of further research and continuation of in-depth investigations of First Nations dialects to assist speech-language pathologists in differentiating these dialectal differences from language impairments.

#### **1.4 The Indian Hospital System**

Indian hospitals were federally operated facilities under the Indian Act of 1876 that allowed the government to oversee the health of Aboriginal peoples. After the Second World War, federal funding for health care services to Aboriginal peoples increased, providing funds to 13 hospitals that maintained racially segregated hospitals for Aboriginal patients (Drees, 2010; PHSA, n.d.) to serve Aboriginal communities suffering from tuberculosis (Drees, 2010). According to Drees (2010), in the late 1940s tuberculosis infection rates were significantly higher for Aboriginal communities than non-Aboriginal communities and the death rate from tuberculosis was ten times higher than the national average.



Various colonial practices were justified and legitimated by the false belief that Aboriginal health could only be achieved through assimilation, consequently involving the development of the federal Indian Health policy. Federal initiatives, such as the Indian Health Services (IHS), a branch of the department of Indian affairs, managed the medical services to Aboriginal peoples (Kelm, 1999). These colonial practices included assimilative goals such as preventing access to non-native medicine for Aboriginal peoples, because there was a fear of pathological contagion or transmission of tuberculosis through cross-cultural interaction (Kelm, 1999; Lux, 2010). In addition to controlling tuberculosis through colonization of medical intervention, the notions of racial superiority and white man's burden were also factors in creating the IHS (Kelm, 1999). Thus, Aboriginal communities were seen as inferior and dangerous by colonizing communities and consequently in need of quarantines and isolation to prevent infection and promote national health (Lux, 2010).

During the period of 1930s to 1960s, there were 17 regional Indian hospitals operating in Canada with three hospitals located in British Columbia: Coqualeetza Indian Hospital at Chilliwack, Miller Bay Indian Hospital in Prince Rupert, and Nanaimo Indian Hospital in Nanaimo (PHSA, n.d.). Nanaimo Indian Hospital was one of the two largest hospitals in western Canada, the other one being Charles Camsell Indian Hospital in Edmonton (Drees, 2010). The Indian hospitals were initially tuberculosis sanatoriums, but eventually admitted Aboriginal individuals with other conditions (Tremonti, 2013). However, infectious diseases, such as small pox and measles, were originally introduced through colonization due to overcrowded and unsanitary housing conditions (Kelm, 1999; PHSA, n.d.). Aboriginal patients received standard tuberculosis treatment with strict routines of bed rest, in which reading or talking was disallowed and was reinforced by nurse patrol (Drees, 2010). In addition, highly controversial vaccines were

experimented on First Nations infants born in the hospitals (Lux, 2010) and invasive procedures to eliminate tuberculosis, such as removal of ribs or lungs, were performed on patients and were used in the IHS system until the 1960s (Drees, 2010).

The development of Indian hospitals was an act of assimilation in the health care system, leaving behind devastating and traumatic impacts on Aboriginal patients and families who survived their hospital experience; however, little is known about Indian hospitals in relation to the history of residential schools. According to Drees (2010), there is a slowly growing body of research exploring the history of Aboriginal peoples in Indian hospitals but limited research is available regarding the perceptions of the recipients, their families, and communities. In addition, archival resources on the Canadian Indian hospital system are uneven, some records on individuals are incomplete, and patient records are generally inaccessible (Drees, 2010).

Similar to survivors of residential schools, survivors of Indian hospitals have already started sharing their experiences as part of the healing process. Former patients from Nanaimo Indian Hospital have come forward to share their stories and were also featured in the news (Walker 2011, 2012). The Canadian Broadcasting Corporation (CBC) program, *The Current*, has also released a podcast titled “Canada’s Segregated Health Care” featuring historians and former patients of Indian hospitals (Tremonti, 2013). Moreover, Drees (2010) collected narratives of survivors of Nanaimo and Charles Camsell Indian hospitals. Across the participants in Drees’s (2010) research, a common theme emerged that emphasized the value of family and community. Participants spoke about feeling distressed and alienated from their home and families; lengthened stays and intolerance of the environment; stress from their illness; impersonal assessment from the medical personnel, and transfer into residential school against their will (Drees, 2010). Overall, the stories illustrate the pain survivors had endured, while also capturing

their humour and resilience. Thus, as part of recognizing the impact of Canada's colonial legacy, including its history of political and social segregation of Aboriginal communities, it is important to consider the historical context of segregated health care in order to understand its significance towards Aboriginal views on western health care, as well as the health disparities and inequalities that manifest today.

### **1.5 Aboriginal Health Inequities and Disparities in Canada**

There are many factors responsible for the differences in health status and inequality in health care faced by the Aboriginal population. These include, but are not limited to, a long history of colonization and assimilation, systemic discrimination, and cultural deprivation (Allan & Smylie, 2015; British Columbia. Provincial Health Officer, 2009). The interplay between racism and colonization leads to racial discrimination, the root of Indigenous health inequities that has continued through generations and that is still currently present in western health care systems today (Allan & Smylie, 2015; British Columbia. Provincial Health Officer, 2009). Thus, the health disparities experienced by the Aboriginal peoples of Canada highlight the importance of further research and intervention plans to understand and address racial discrimination and its impact on Aboriginal health, as well as the development of services and programs that recognize the consequences of racism on Aboriginal people's health, well-being, and their ability to cope (Allan & Smylie, 2015).

Aboriginal health research in Canada has grown in recent years (Young, 2003); however, according to Allan & Smylie's (2015) report, the current research literature has not adequately examined the health needs of the Aboriginal population in Canada. Young (2003) reviewed the health research conducted from 1992 to 2001 among Canadian Aboriginal peoples to determine if the existing research has provided a comprehensive examination of the health needs of the

Aboriginal population. Young's (2003) literature search showed an under-representation of the Métis population, urban Aboriginal residents, and First Nations peoples living off reserves. Urban aboriginal peoples refer to citizens of First Nations, Métis, and Inuit peoples who live in urban areas (Environics Institute, 2010). Out of 254 papers, only two papers referred to the Métis population, five to urban Aboriginal people, and two to First Nations people not living on Indian reserves (Young, 2003). Meanwhile, there have been more studies of the Inuit population than other Aboriginal groups, with 122 papers providing data on that group. Moreover, no papers were found related to rehabilitation (Young, 2003). While most comparative studies implicitly assume that the non-Aboriginal population is the "ideal" or the norm that Aboriginal health should achieve, Young (2003) also noted that 138 papers did not specify a comparison group. Overall, the findings showed that there are gaps within the research literature, which has failed to fully represent the demographic composition of Canadian Aboriginal peoples.

Two major surveys, the Urban Aboriginal Peoples Survey (UAPS; Environics Institute, 2010) and the First Nations Regional Health Survey (RHS) 2008/10 (First Nations Information Governance Centre [FNIGC], 2012), explored the experiences of Aboriginal peoples with racism and its impacts on their health, well-being, and access to health services in Canada. The UAPS (Environics Institute, 2010) drew on an income-stratified convenience sample of Aboriginal people across 11 Canadian cities, which included 2,614 person-to-person interviews with First Nations peoples (status and non-status), Métis, and Inuit in Vancouver, Edmonton, Calgary, Regina, Saskatoon, Winnipeg, Thunder Bay, Montreal, Toronto, Halifax, and Ottawa. The target population for the RHS was restricted to only the First Nations population. A largely standardized sample size was used to survey a total of 216 First Nations communities across Canada (FNIGC, 2012).

The UAPS investigated urban Aboriginal peoples' experiences with non-Aboriginal services and whether the respondents had experienced any discrimination because of their identity. The health care system was ranked as the second most recently used non-Aboriginal service by urban Aboriginal peoples at 84% (Environics Institute, 2010). For the respondents who had recently accessed the health care system, 82% reported that their experience was "generally positive" (Environics Institute, 2010, p. 83). Several urban Aboriginal peoples who had negative experiences were asked to describe their experience (Environics Institute, 2010). The following quote of a negative experience in the health care system was presented in the report:

A doctor immediately separated me from other Aboriginal people by saying, 'You must have been one of the few' who made it, because I seem educated and speak well. I tried to educate the doctor about prejudice. I found this unfair to others, a generalization.  
(Environics Institute, 2010, p. 84)

Furthermore, 43% of respondents reported that their experience was a form of racism or discrimination through unfair or disrespectful treatment or felt that the staff was judgmental, mean, rude, or lacked empathy and did not understand or believe their needs and culture (Environics Institute, 2010). Interestingly, regardless of whether the respondents were users or non-users of non-Aboriginal services or whether their experiences had been positive or negative, most urban Aboriginal peoples believe it is very important to have Aboriginal services available in addition to current non-Aboriginal ones. In particular, 76% of the respondents reported Aboriginal health centers as being one of the top Aboriginal services that are needed (Environics Institute, 2010).

The RHS documented barriers faced by First Nations adults surrounding western health

care access. These barriers included those related to First Nations-specific needs (i.e., culturally appropriate services), those related to geography and availability of services, economic barriers (i.e., care and transportation costs), and systemic barriers (i.e., Non-Insured Health Benefits [NIHB] approval; First Nations Centre, 2005; FNIGC, 2012). While NIHB was developed to improve the overall health status of Aboriginal peoples, the RHS results showed that the current access rules to NIHB may be creating more barriers rather than alleviating them. The types of NIHB access problems reported by respondents included access to medication, dental and vision care, transportation services or costs, escort travel, and hearing aids (First Nations Centre, 2005; FNIGC, 2012).

Overall, 49.0% of First Nations adults rated their access to western health care services as being equivalent to the rest of Canadians, whereas 12.4% rated their health access as better and 38.6% rated it as being poorer than the general Canadian population (FNIGC, 2012). The percentage of First Nations who felt that they had the same level of health access as the general Canadian populations increased from 40.8% since the previous RHS 2002/03 (First Nations Centre, 2005); however, the findings still suggest inequities in First Nations' access to health care. Furthermore, the RHS 2002/03 (First Nations Centre, 2005) found that respondents who were from remote or isolated communities were more likely to rate their access to health services as poorer than that of other Canadians.

## **1.6 Efforts to Minimize Aboriginal Health Inequities and Disparities in Canada**

Given what the research findings have shown thus far in regard to Aboriginal health inequities and disparities, Allan and Smylie (2015) suggest that there are different areas necessary to target in order to address racial discrimination: health policy; research; service provision; and training and continuing education of health care professionals. Additionally, the

authors also point out that there has been evidence of resilience and positive initiatives that have emerged in managing racial discrimination at the individual, family, and community level. Many community-directed programs, such as First Nations-controlled health services and community health centers, were also created to address specific or general health needs (Allan & Smylie, 2015). These programs help to improve health inequities and disparities Aboriginal peoples currently face in today's health care system. For example, rural Métis communities have been reported to organize community-based fundraisers to raise funds to cover travel costs for community members to access specialized health services located outside of their communities (Allan & Smylie, 2015).

The First Nations Health Authority (FNHA), an example of a First Nations-controlled health service, is the first province-wide health authority in Canada and was established to provide a variety of health services and programs for First Nations peoples living in British Columbia (Allan & Smylie, 2015). In the fall of 2013, the administration, management, and funding of federal health services and programs were transferred to FNHA that were formerly managed by the Pacific Region First Nations Inuit Health Branch. Governed by British Columbia First Nations, the goal of FNHA is to develop services and policies that are specific to First Nations individuals and communities and to close health gaps to improve the health and well-being of First Nations peoples (Allan & Smylie, 2015).

Employment of Indigenous staff in specific roles has been created within mainstream institutions to improve access and services for Indigenous peoples. The creation of these specialized roles, which includes the Aboriginal Patient Navigator and the Aboriginal Patient Liaison for Aboriginal patients, serves to support and advocate for Aboriginal people's health care. In particular, the Aboriginal Patient Navigator is responsible for serving as a bridge

between Aboriginal patients and the health care system (Vancouver Coastal Health, n.d.-a). The role of the Aboriginal Patient Navigator can range from attending health care team meetings and facilitating access to cultural health resources and support to providing workshops and in-service training for health care staff to improve cultural sensitivity (Allan & Smylie, 2015). An evaluation of Northern Health's Aboriginal Patient Liaison program (Foreman & Stewart, 2011) reported a positive impact of the specialized role in improving the health care outcomes and access to health care.

In regard to the development of a curriculum focusing on the health of Aboriginal children in Canada, Saylor (2012) noted that there is minimal formal teaching surrounding the health of Aboriginal peoples in medical schools and residency programs; however, training programs have been growing steadily in recent years. Additionally, Allen and Smylie (2015) reported a steady emergence of policy statements and guidelines for medical professionals and medical training organizations in Canada towards identifying and developing competencies needed by health care professionals. This includes the development of educational guidelines, curricula, and training programs for medical and nursing professionals and trainees (Allen & Smylie, 2015).

### **1.7 Cultural Competency and Cultural Safety**

As discussed in the previous sections, Aboriginal peoples face disproportionate health care disparities and inequalities compared with the non-Aboriginal population in Canada. Additionally, the National Aboriginal Health Organization (2008) reports that health care providers lack skills to appropriately address cultural differences. Thus, there is a need to establish cultural competency and cultural safety within the health care system to address these issues. Originated in the 1980s in New Zealand, the term cultural safety was developed in



response to discontent with nursing care encountered by the Māori people (National Aboriginal Health Organization [NAHO], 2006).

According to the National Aboriginal Health Organization (2006), cultural safety is situated on a continuum of care. Through the learning process of providing culturally appropriate care, the health care provider first reaches cultural awareness, then cultural sensitivity, and lastly cultural safety, which is the result of culturally competent care. While cultural awareness and cultural sensitivity involve increasing the knowledge of health care providers, cultural safety is an outcome and is defined and experienced by Aboriginal patients who receive the service (Health Council of Canada, 2012; NAHO, 2006). The concept of cultural safety is continuously evolving, addressing issues of power imbalances, institutional discrimination, and colonialism in the health care setting. As defined by the Nursing Council of New Zealand, culturally unsafe practice comprises of “any actions that diminish, demean, or disempower the cultural identity and well being of an individual” (NAHO, 2006, p. 1).

According to the Health Council of Canada (2012), cultural competency is established when a health care environment is free of racism and stereotypes and Aboriginal peoples are treated with empathy, dignity, and respect and considered as partners in the decision-making process. Health care providers who are culturally competent are more likely to recognize and understand the colonial process and its impact on Aboriginal health, thus adapting the way that care is provided to effectively meet their patient’s unique needs. Culturally competent health care providers do not make assumptions about people’s cultures, have the skills necessary to obtain information about their patient’s needs and willingness to advocate for it, and recognize that Aboriginal communities are diverse and do not all have the same beliefs, cultural practices, and

languages (Health Council of Canada, 2012). As a result, a trustworthy and respectful relationship can be built between the health care provider and the Aboriginal patient.

Overall, when cultural safety is in place, Aboriginal peoples are more likely to use health care services and follow treatment advice when they feel safe to trust their health care providers (Health Council of Canada, 2012). Reciprocally, implementing successful culturally competent skills helps to increase confidence and morale for health care providers when they see an increase in their patients' willingness to follow treatment advice along with improvements in their health and well-being (Health Council of Canada, 2012).

### **1.8 Approaches to Working with Aboriginal Adults with Acquired Brain Injury in Speech-Language Pathology Contexts**

Currently, little research is available surrounding approaches to working with Aboriginal adults with acquired communication disorders in the context of speech-language pathology. As stated by Hersh et al.'s (2014a), "if speech pathology is going to be accessible, relevant and culturally appropriate for Indigenous people with acquired communication disorders, then there needs to be a greater attention to the experiences of both clinicians and clients in rehabilitation and how they deal with these disorders in the longer term" (p. 7). Recent research in the area of working with Aboriginal clients with ABI has focused on representing perspectives of health care professionals, as well as Aboriginal clients themselves, to raise awareness and highlight their experiences and challenges encountered in various processes in the health care system from acute to rehabilitation to community services (Armstrong, Hersh, Hayward, Fraser, & Brown, 2012; Hersh et al., 2014a; Hersh et al., 2014b; Keightley et al., 2011a; Keightley et al., 2011b; Keightley et al., 2009).

The risk of ABI being higher for the Aboriginal population has also been identified as a concern in the Canadian, Australian, and New Zealand studies (Hersh et al., 2014b; Keightley et al., 2009; McLellan et al., 2014). Similar themes and challenges were found throughout these studies. For example, participants who were health care professionals reported their own lack of knowledge regarding Aboriginal cultures and resources across the different studies. However, there were also unique themes, facilitators, and challenges that emerged from each study, which may reflect the differences in each study's geographical location. Thus, this research literature review is organized by geographical locations to explore similarities and differences from their regionalized perspectives, including service delivery models and the different health care professionals involved in the studies.

### **1.8.1 Australia**

Research in Australia has recently drawn attention to the clinical practice with Aboriginal clients with ABI, specifically focusing on perspectives from the field of speech-language pathology. Hersh et al. (2014a) first conducted a narrative analysis of an interview with a speech-language pathologist's work with Indigenous Australians with ABI in the Northern Territory. From this study, the authors were able to continue and expand the research by drawing on the data from the narrative analysis to develop a survey for a larger population. The authors stated that the narrative analysis allowed for focused sampling and information gathering (Hersh et al., 2014b), which are strategies designed to improve the validity of survey instruments (Fossey, Harvey, McDermott, & Davidson, 2002). The survey was completed by 112 speech-language pathologists who have worked in the field of ABI, examining: their level of experience with Aboriginal clients; practices in assessment, treatment and discharge; liaison experience with

families, Aboriginal Health Workers, Aboriginal Liaison Officers and interpreters; cultural competency training; and potential sources of support (Hersh et al., 2014b).

The results from the national survey parallel those of their narrative analysis study, with similar themes and challenges reported. Many speech-language pathologists reported a lack of knowledge about Indigenous culture and support, thus resulting in lower levels of confidence when working with Indigenous clients. This concern was also raised in the narrative analysis, as Hersh et al. (2014a) suggested that the participant was describing “feeling a loss of professional knowledge and assumptions” (p. 3). The survey findings revealed that only a few speech-language pathologists see large numbers of Aboriginal clients, which suggests that there are fewer opportunities for the speech-language pathologists to gain confidence and develop appropriate services to meet the needs of their Aboriginal clients (Hersh et al., 2014b). From these challenges, the theme of flexibility and awareness of cultural context emerged, in which clinicians needed to learn to adapt and develop new ways to address their clients’ needs.

Armstrong et al. (2012) conducted a qualitative study focusing on three Indigenous patients, from the Perth metropolitan area, who were a minimum of 3-months post-stroke and diagnosed with aphasia. The participants were involved in semi-structured interviews that explored: issues of barriers and facilitators encountered; experiences of communication difficulty in day-to-day life; attitudes of others towards communication difficulty; hospital experiences; and experiences of speech-language pathology services. All three also had other significant and ongoing health concerns that they emphasized during their interviews; however, the participants spoke little about their aphasia specifically, focusing instead on other aspects of their identities. For example, the participants attended support and activity groups to maintain social relationships post-stroke, which Armstrong et al. (2012) interpreted as “an implicit valuing of

communication” (p. 278). Additionally, although the participants reported satisfaction with their hospital experiences, none had received long-term speech-language pathology services nor did they express interest in having more service. Armstrong et al.’s (2012) study gives insight into the notion of living successfully with aphasia from an Aboriginal cultural perspective, based on studies which have shown that disabilities are constructed differently in traditional Australian Aboriginal cultures (Ariotti, 1999; Boddington & Räisänen, 2009). Australian Aboriginals’ construct of health is broad and holistic (Ariotti, 1999; Boddington & Räisänen, 2009). Accordingly, holistic health is linked to physical, social, and emotional aspects of health, which includes cultural well-being, temporal holism (i.e., cyclical concept of life-death-life), self-determination and control, and community (Boddington & Räisänen, 2009). Thus, a sense of community and family connections, through communication and social relationships, was valued and emphasized more than the impairment itself in the three interviews.

Despite their high rates of stroke, Aboriginal clients in Australia are relatively under-represented in speech-language pathology services due to under-referral, early discharge, or self-discharge (Armstrong et al., 2012). Further, Hersh et al. (2014b) state that Aboriginal clients are placed in an unsatisfactory situation of experiencing disproportionately greater burden for stroke compared with non-Aboriginal clients, with a decreased likelihood of receiving quality care in a hospital setting. The health care system currently favours the movement of clients from remote communities to resource-heavy urban areas, which may be an inappropriate model of service delivery for many Aboriginal people (Hersh et al., 2014a). For instance, the participants in Armstrong et al.’s (2012) study were all from rural areas initially, and now live in the Perth metropolitan area. Thus, Aboriginal clients face large social and cultural adjustments, which are further compounded by their ABI. Therefore, the studies by Hersh et al. (2014a, 2014b) and

Armstrong et al. (2012) emphasized the greater need to offer more flexible services to adapt and provide culturally appropriate and sensitive assessment and treatment. For example, providing flexible services may include revising assessment and treatment approaches, such as using informal assessments and changing how progress is measured and goals are set (Hersh et al., 2014a). In addition, the studies highlighted the importance of learning about Aboriginal culture and working closely with Aboriginal liaison officers and interpreters.

### **1.8.2 New Zealand**

Māori, the indigenous people of New Zealand, face a higher incidence of aphasia than non-Māori, calling for a need for further research in this area. In particular, Māori with stroke and their families have expressed the need for more speech-language pathology services and guidance from speech-language pathologists (Harwood, 2012, as cited in McLellan et al., 2014, p. 455). McLellan et al.'s (2014) study used a combination of Kaupapa Māori Research (KMR) and interpretive description (ID) to describe experiences of Māori with aphasia and their whānau (extended family) in order to improve speech-language pathology services to this population. Following the political and ethical guidance provided by KMR helped represent data from a Māori perspective and ensured that the research maintained relevancy to Māori society and cultural appropriate delivery. In combination with ID, the research was made applicable and accessible to clinicians as well.

Approximately 25 participants were involved in the study, where in-depth interviews were conducted with 11 Māori with aphasia and their nominated whānau that centered on their experiences regarding aphasia-related changes in relationships, health, spirituality, activities, and family and community relationships. McLellan et al. (2014) were able to include the voices of the individuals with aphasia by offering the flexibility to various modes of communication (e.g.,

gestures, facial expressions, and drawing). Their voices were represented in the article through quotes, including paraphasias and apraxia errors with the transcriber's interpretation of meaning. Similar to Armstrong et al.'s (2012) findings, McLellan et al. (2014) noted that it was impossible to fully separate the impact of aphasia from the overall impact of stroke in the participants' lives, as they conceptualized everything related to stroke as one entity.

Experiences of aphasia were categorized into two pairs of themes: (1) "grieving for what is lost" and "recognizing what we have got", and (2) "it is hard" and "choosing how to respond". The first pair of themes is a one-to-one relationship that depicted equal yet contradictory experiences that illustrated the participants' concurrent feelings of grief and gratefulness. For example, one pair of particular focus was "tragic loss [of] language and communication" and "you count your blessings" (McLellan et al., 2014, p. 461). In the second set of themes, participants described the challenges they faced living with aphasia, while also conveying a range of negative emotions and demonstrating how they responded and managed their emotions and recovery process.

The authors stated that aphasia can have profound effects on Māori families and bring changes to family roles and relationships. Although whānau can actively manage their given situation and enable the person with aphasia to participate in the whānau and community, struggles were still encountered. For example, in Māori society, a child who takes over the parent's role while the parent is alive may diminish the parent's mauri (life force). Nonetheless, taking responsibility for the well-being of the person with aphasia reflected a deep and spiritual presence of indivisibility of the individual and the whānau well-being because, as one whānau participant described, "he's one of us" (McLellan et al., 2014, p.467).

### **1.8.3 Canada**

A resource kit, compiled by Kay-Raining Bird (2014), for speech-language pathologists and audiologists was included in the 2014 CJSIPA issue to assist health care professionals in providing culturally and linguistically appropriate services to Aboriginal peoples. The resource kit outlines: various research-based clinical resources developed by SAC; government, provincial, and territorial websites; Aboriginal organization websites; resources related to Canada's colonial history and Aboriginal dialects and languages; and information on cultural safety that health care professionals can readily access to further support their own learning, as well as improving service delivery for Aboriginal peoples. While the resource kit is not intended to be comprehensive (Kay-Raining Bird, 2014), no specific information is provided regarding Aboriginal adults with acquired communication disorders resulting from brain injury.

Researchers from northwestern Ontario have begun to explore perspectives of working with Aboriginal clients with ABI and included perspectives of health care professionals as well (Keightley et al., 2009, 2011a). However, these studies were tailored towards health professionals in general or specifically to occupational therapy (Keightley et al., 2011b). The disadvantages that Aboriginal clients with ABI face are concerning; as Keightley et al. (2011b) state, the risk of poor outcomes after an injury increases, due to factors such as geographical isolation, socioeconomic status, and psychosocial factors, which all already affect the health needs of Aboriginal peoples. Keightley et al.'s (2009) first study surveyed health care practitioners and explored rehabilitation challenges for Aboriginal clients recovering from ABI. The range of health care professionals that were included in the study included nurses, program managers, Aboriginal mental health workers, physicians, solvent abuse counselors, an occupational therapist, and a psychologist. The authors touched upon a few challenges that were



also noted in the two studies by Hersh et al. (2014a, 2014b), such as the need to provide culturally appropriate services and the necessity of relocating Aboriginal clients from remote communities to urban areas due to lack of resources. The trend of relocating Aboriginal clients from rural to urban areas not only raises cultural challenges, but it also suggests that there is a lack of rehabilitation services and discharge planning for Aboriginal clients from remote communities (Keightley et al., 2009). Overall, five main themes emerged from the survey's results that highlighted common areas of interest and concerns that surround Aboriginal communities: (1) practitioners' experience with brain injury; (2) practitioners' experience with Aboriginal clients; (3) specialized needs of Aboriginal clients recovery from brain injury; (4) culturally sensitive care; and (5) traditional healing methods as part of recovery.

Although Keightley et al.'s (2009) study did not focus on speech-language pathology services specifically, the findings highlighted many noteworthy challenges faced by health care practitioners in a Canadian context that were not mentioned by the speech-language pathologists in Hersh et al.'s studies (2014a, 2014b). For example, one notable challenge was that Aboriginal clients often present with additional health conditions, a factor that was also mentioned in Armstrong et al.'s (2012) study. Thus, education for practitioners in treating these underlying problems, in addition to the development of a comprehensive, team-based approach to treatment, is one step forward to providing better services to the Aboriginal population. Keightley et al. (2009) also raised the topic of using traditional healing methods. Many Aboriginal peoples do not practice traditional healing methods themselves, and are instead referred to traditional healers through government-funded services. Finding the balance of combining western medicine and traditional healing methods may be important, because the use of traditional healing methods during the process of recovery helps Aboriginal clients reconnect with who they are, increases

self-esteem, and reduces anxiety (Keightley et al., 2009). However, it was reported that not all clients were interested in traditional healing methods; for example, those who identified as Christians or were affected by residential schooling were less likely to be interested in traditional healing methods, while young people were found to be more actively adopting the practices (Keightley et al., 2009).

Keightley et al.'s (2011a) study examined the barriers and enablers around transition from health care services to home communities for Aboriginal clients recovering from ABI. This study included perspectives from clients with ABI, their caregivers, and hospital and community health care workers. Keightley et al. (2011a) raised an important concern in describing the need to explore how the transition process is affected by minority and ethnic status for Aboriginal clients. A retrospective study comparing Saskatchewan Aboriginal Canadians and non-Aboriginal Canadians with TBI who were admitted in the Saskatoon City Hospital inpatient rehabilitation unit found that native North American patients were less likely to be offered post-discharge resources than non-native North American patients (Blackmer & Marshall, 1999). Blackmer and Marshall (1999) explained that this discrepancy may be due to cultural factors. For example, native North American patients and families may tend to rely on support from their own community; therefore, they are less likely to involve health care professionals from the outside community and use post-discharge resources.

Lack of awareness, education, and resources in both the acute and community care were among some of the challenges the participants reported (Keightley et al., 2011a), which were also reflected in Hersh et al.'s study (2014b). Health care practitioners reported poor discharge procedures at hospitals, leading to inadequate community services for Aboriginal clients upon their return to home. Moreover, Aboriginal clients expressed the need for home services, as they

faced difficulty in accessing these services due to regulated hourly restrictions and inconsistency in service delivery. As a result, geographical isolation causes further challenges of service accessibility, in which Aboriginal clients in remote communities are faced with long travel distances and personal sacrifices to receive community services. Aboriginal clients may also face funding difficulties that lead to poor service delivery. Similar to Keightley et al.'s (2009) first study, the participants reported the challenge of finding balance between the western conventional medical system and traditional views, where First Nations traditional healing methods can be an important part of the process to recovery and well-being (Keightley et al., 2011a). Participants recommended the development of educational and screening tools, as well as the need for further assessment to help improve transitions for Aboriginal clients.

Improvement in assessment materials can help to identify areas of service delivery, as well as to support future funding requests (Keightley et al., 2011a).

The two studies (Keightley et al., 2009, 2011a) have drawn attention to traditional healing methods, although little is known in regard to its role in First Nations recovery of ABI. Keightley et al. (2011b) state that there is a lack of information available regarding cultural beliefs and traditional teachings and lack of knowledge about how cultural ideas affect First Nations peoples' perception of rehabilitation needs and access to services; this finding led to the development of their study to explore views of healing brain injury from perspectives of First Nations' elders and traditional healers in First Nations communities served by Wassay-Gezhig-Na-Nahn-Dah-We-Igamig (Kenora Area Health Access Centre; Keightley et al., 2011b).

Although Keightley et al.'s (2011b) study was intended to gear towards clinical implications for occupational therapy practice, it differed from their earlier studies in that the focus group involved only participants from First Nations background, thus offering deeper insight into their

perspectives of ABI recovery. Ten participants with experience working with individuals with ABI were involved in the study. Eight of the 10 participants identified as Ojibway, and overall the focus group represented six of the 10 First Nations communities receiving services from the Kenora Area Health Access Centre. Their roles included traditional healer, cultural coordinator, elder, mental health case manager, and helper to the traditional healer.

The data revealed four themes: (1) pervasiveness of spirituality, (2) “fixing” illness or injury versus living with wellness, (3) working together in treating brain injury, and (4) financial support needed for traditional healing (Keightley et al., 2011b). The participants expressed their cultural belief in the importance of attending to one’s spirit as part of health and wellness maintenance, rather than solely focusing on body functions, which is a common emphasis in Western medicine. Thus, traditional healers are seen as holistic practitioners who address the body, mind, and spirit, and use traditional medicines and ceremonies on a daily basis to maintain health and wellness (Keightley et al., 2011b). The participants also expressed interest in uniting Western and traditional approaches to treat individuals with brain injury. However, in order to achieve this, they need more information from the Western perspective, such as how to treat and detect brain injury. Financial support was noted as an essential component to support traditional healing during the process of recovery, because traditional healers do not receive outside funding from government or insurance sources that physicians receive (Keightley et al., 2011b). Therefore, lack of funding can be a barrier to providing and receiving traditional healing services. For example, traditional healers may need to travel and stay with families who need support in hospitals during acute or palliative phases of brain injury. Furthermore, the participants reported the need for raising awareness within First Nations, medical, and academic communities to acknowledge traditional healing as a viable option.

## **1.9 Implications for Research in Working with Aboriginal Adults in British Columbia**

As shown by the above literature review, the topic of service delivery to Aboriginal clients with ABI has been explored in various ways by researchers from three different countries: Australia, New Zealand, and Canada. The Australian studies focused the research in a speech-language pathology context by conducting a narrative analysis on one speech-language pathologist's work (Hersh et al., 2014a) and a national survey (Hersh et al., 2014b), as well as a narrative analysis from three Aboriginal clients' experiences with speech-language pathology services (Armstrong et al., 2012). Studies from New Zealand have also tailored their research to fit in a speech-language pathology context, specifically looking at Māori and whānau experiences with aphasia (McLellan et al., 2014). Although their research is geared towards improving speech-language pathology services, the New Zealand studies have only represented perspectives from Aboriginal clients with ABI and not from speech-language pathologists. Finally, Canadian studies from northwestern Ontario conducted research that explored perspectives from health care professionals (Keightley et al., 2009) and Aboriginal clients with ABI (Keightley et al., 2009; Keightley et al., 2011a), a cultural coordinator; mental health care workers; elders; and traditional healers (Keightley et al., 2011b), but none were in a speech-language pathology context.

Overall, the perspectives represented in these studies help to pave the way in exploring and understanding the challenges encountered by clinicians and by Aboriginal clients with ABI. The studies not only show the need for broader research in the area of working with Aboriginal clients with ABI, but also shed light on the need to understand the relevant issues that Aboriginal clients with ABI and speech-language pathologists may face in the health care system, such as the long-term recovery process, policies regarding services and discharge, revision of assessment

and treatment procedures, and expectations of Aboriginal peoples. Collectively, these studies suggest that there is a need to reorganize rehabilitative services in the health care system to ultimately provide culturally safe practice to the Aboriginal population. However, research regarding approaches to working with Aboriginal clients with ABI in a speech-language pathology context is absent in the Canadian literature. Albeit from different perspectives, the research from Australian and New Zealand literature is specifically relevant to speech-language pathology and illustrate that there is sufficient evidence for regional differences to justify the need to explore this topic in Canada. Expanding the Canadian literature to include speech-language pathology perspectives is an important step to providing culturally safe care to Aboriginal peoples. Given British Columbia's diverse Aboriginal cultures, research conducted in this province will be able to contribute valuable information that is unique to not only the province's health care system, but also to the Aboriginal communities across British Columbia. The overall research objective of the current study is to explore the perspectives of speech-language pathologists who have a background in working with Aboriginal clients with ABI in British Columbia.

## **Chapter 2: Methodology**

Because there is limited research in speech-language pathology related to approaches to working with Aboriginal adults with an acquired communication disorder resulting from brain injury, an exploratory research paradigm is a necessary first step in addressing the objectives of this study. Accordingly, the research questions were investigated using qualitative procedures, based on Creswell's (1994) criteria in selecting a suitable research paradigm. A descriptive and exploratory study was undertaken to delineate supports, barriers, and facilitators that speech-language pathologists working in British Columbia encounter when working with Aboriginal clients with ABI. In order to provide a basis for systematic description of participants' perspectives, thematic analysis was undertaken to identify themes and topics that emerged from interview data.

The study was conducted using semi-structured interviews and analyzed through thematic analysis. The specific research questions that I addressed are:

- (1) How do the participants characterize their overall experiences with working with Aboriginal clients with ABI? In particular, what challenges, barriers, and/or facilitators do they encounter regarding referral, assessment, treatment, discharge, working with Aboriginal support workers, team meetings, and community services?
- (2) How do the participants provide culturally safe care for their Aboriginal clients? Specifically, what have they done to prepare or educate themselves to implement culturally safe care in their clinical practice?

### **2.1 Methodological Framework**

Qualitative research has a vital and active presence in the field of speech-language pathology and many researchers are conducting qualitative studies to contribute to the growing

research literature surrounding communication disorders. Damico and Simmons-Mackie (2003) define qualitative research as “a variety of analytic procedures designed to systematically collect and describe authentic, contextualized social phenomena with the goal of interpretive adequacy” (p. 132), thus outlining four main criteria employed in qualitative research that also align with Creswell’s (1994) criteria: orientation towards social phenomena; contextualization and authenticity; systematicity in data collection; and descriptive adequacy. However, Creswell (2007) subsequently provided more comprehensive criteria, adding that qualitative researchers, as the primary instrument of data collection, are focused on the process and are interested in the meaning drawn from the data. Thus, participants’ perspectives are the main focus of the research. As such, qualitative research has a number of key characteristics that make it well-suited for the purposes of this study. Because of its flexible quality in comparison with quantitative research, qualitative research is often the chosen research paradigm when an area of interest calls for exploration, particularly when limited research is available.

Amongst the array of different theoretical qualitative research frameworks, “qualitative description” has emerged as an approach that is found to be appropriate for descriptive studies designed to explore issues in applied health research (Sandelowski, 2000). Sandelowski (2000) argues that qualitative description is a valuable method by itself and is suitable to provide a comprehensive summary using “everyday terms of those events” (p. 336). In such studies, qualitative description can be implemented using principles of qualitative research to provide a straight description of a research area of interest. Thus, for the purposes of this exploratory study, qualitative description was selected as the most appropriate methodological approach to accurately represent the collective experiences of a group of speech-language pathologists working with Aboriginal adults with ABI. With semi-structured interviews as the main source of



this study's data collection, qualitative description allows the researcher to stay close to the data to represent the speech-language pathologists' perspectives in a coherent and organized manner, ultimately strengthening descriptive and interpretive validity (Sandelowski, 2000).

## **2.2 Participants**

This research study used purposive sampling (Fossey et al., 2002; Creswell, 2007) to recruit speech-language pathologists as participants and the key informants of this study. As defined by Thorne (2008), the term "informant" refers to individuals who are particularly familiar with the relevant elements being investigated and who are also willing to take the time to explain the elements of interest. The speech-language pathologists were from a range of health care settings and health service authorities to cover different geographical locations within British Columbia. Preliminary exploration of potential participants was first conducted through contacting speech-language pathologists in areas likely to have worked with Aboriginal clients with ABI. Five health services authorities across British Columbia were selected to reflect a broad range of speech-language pathologists' experiences working with Aboriginal clients with ABI from different health care settings and geographical locations. A total of seven speech-language pathologists were recruited, each with at least five years of work experience. The following subsections outline the selected health services authorities, with a brief description of the regions the health authority covers, as well as reasons for why they were chosen for the study.

### **2.2.1 Vancouver Island Health Authority**

Vancouver Island Health Authority provides health services to more than 765,000 people on the Vancouver Island, the islands of the Georgia Strait, and the mainland communities north of Powell River and south of Rivers Inlet (Vancouver Island Health Authority, n.d.-b). A speech-

language pathologist from a regional hospital providing service to Aboriginal patients, including those from remote communities, agreed to participate in the study.

### **2.2.2 Northern Health**

Northern Health serves approximately 300,000 people located in the northern half of British Columbia, where many rural Aboriginal communities are located (Northern Health, n.d.-b). Two speech-language pathologists who work in a regional hospital providing services to Aboriginal clients from the northern half of British Columbia agreed to participate in the study.

### **2.2.3 Vancouver Coastal Health and Providence Health Care**

Both Vancouver Coastal Health and Providence Health Care are in the Metro Vancouver area. Vancouver Coastal Health provides health services to the Greater Vancouver area, which includes Vancouver, Richmond, North and West Vancouver and along the Sea-to-Sky Highway, Sunshine Coast, and BC's Central Coast (Vancouver Coastal Health, n.d.-b). Providence Health Care operates seven health care facilities in the Vancouver Coastal region (Providence Health Care, n.d.). Two speech-language pathologists from a hospital providing intensive rehabilitative services to patients from all over British Columbia and one speech-language pathologist from an acute care facility agreed to participate in the study.

### **2.2.4 Interior Health**

Interior Health provides services to the southern interior of British Columbia that includes areas such as Thompson Cariboo Shuswap, Okanagan, Kootenay Boundary, and East Kootenay (Interior Health, n.d.-b). A speech-language pathologist from the regional hospital providing services to many Aboriginal communities in the Interior agreed to participate in the study.

### **2.3 Harmonized Ethics Review**

In the process of this research study's ethics approval, the Harmonized Ethics Review Board initially suggested including a definition of cultural safety for participants before they were interviewed. Their rationale was that this would allow participants during interviews to come from a place of common understanding around where they are placed on the continuum of providing culturally safe care (from cultural awareness through to cultural safety). However, the Board agreed that, given the exploratory nature of the research, a case could be made for not providing a definition at the outset. The speech-language pathologists in this study come from different education backgrounds and experiences in working with Aboriginal peoples that shape their clinical practice. As this study focuses on their perspectives in approaches to working with Aboriginal adults with ABI, a first step in understanding participants' current practice in implementing culturally safe care is by asking questions about what culturally safe care means to them (see Appendix A for interview guide). Thus, instead of beginning with a literature-based definition of cultural safety, a description of cultural safety was instead provided for participants upon completion of the research project along with a summary of key findings. In addition, a list of relevant resources is included for the speech-language pathologists at the end of this thesis (see Appendix B).

A second concern of the Ethics Board was that, because culturally safe care can really only be determined by the recipient of care, steps should be taken to ensure that the research findings present speech-language pathologists' perspectives without privileging them in any way to the exclusion of Aboriginal understandings. To strengthen the third interview question that asks participants about their understandings of cultural safety, the following questions were included in accordance with the Harmonized Ethics Review Board's suggestions: "how do you

know you are providing culturally safe care?"; "do you check with your clients?"; and "what have you done to prepare or educate yourself to provide culturally safe care?"

## **2.4 Data Collection**

Semi-structured, participant-driven interviews were conducted with the speech-language pathologists to explore their experiences of working with Aboriginal clients with ABI in British Columbia. Semi-structured interviews are widely used in qualitative research where key informants are given the opportunity to express their "complex stock of knowledge" (Flick, 2002, p. 80). As outlined by both Flick (2002) and Kvale (1996), various types of interview questions can be used to make the key informants' implicit knowledge more explicit, in addition to opening the dialogue for further elaboration on certain significant topics that they may present during the interview. The type of questions mainly used in this study included open-ended, follow-up, and probe questions. The questions asked were related to the participants' experiences working with Aboriginal clients with ABI and views on culturally safe care, followed by probe or follow-up questions to further explore specific issues that arose during the interview (see Appendix A for interview guide). Upon completion of the interviews, participants took part in an additional follow-up meeting for member checking (Creswell, 1994), as described further in the next section.

Each semi-structured interview was approximately one hour, except for one interview that was approximately 30 minutes. The interviews were conducted individually via Medeo (n.d.), a British Columbia third-party secure online platform service for video conferencing that meets requirements for use in health care, or in person. All interviews with participants from the Metro Vancouver area were conducted face-to-face, while interviews with participants from outside of Metro Vancouver were held via Medeo. Medeo was used solely to conduct interviews

and was not used for data capture or storage. Interviews were recorded with a Marantz PMD661 recorder. In addition, Soundflower, a Mac operating system extension that allows internal audio recording, was used as a backup recording for interviews conducted via Medeo.

## **2.5 Data Analysis**

The interviews were orthographically transcribed verbatim from the audio recordings. In the representation of spoken text as presented in the results section, there were rare instances in which part of the quote was typically omitted to exclude non-contributory content, such as back-channeling from the researcher (e.g., “mhm”). Other omissions included specific place names to protect the participant anonymity and confidentiality. The conventions used to represent these types of omissions are enclosed with square brackets (e.g., [place]). Overall, efforts were made to ensure that omissions did not change the meaning of the quote. Additionally, the research supervisor reviewed the transcripts for reliability of transcription and interpretation of data.

Member checking was used to ensure internal validity in the study (Creswell, 1994). Participants took part in one additional brief follow-up meeting via telephone. The purpose of the meeting was to clarify any uncertainties that arose from transcription and to verify interpretations from the analysis. Each participant was provided with a copy of the results chapter, which included her own quotes but excluded those of all other participants. Participants verified with the researcher that the meaning given to the quote was what she intended. Each follow-up meeting was approximately 15 minutes long.

Thematic analysis was used to interpret the interview data. The aim of thematic analysis is to explore relationships drawn from the data in order to meaningfully describe the collective clinical experiences of the speech-language pathologists with a background in working with Aboriginal adults with ABI. While there are various ways to conduct thematic analysis and to

define themes, Luborsky's (1994) technique for thematic analysis on qualitative semi-structured interviews builds a frame of reference through both the participants' perspectives and the researcher's observations and interpretations. With an emphasis on using direct representations of the participants' own views and descriptions of their experiences, beliefs, and perceptions to illustrate emergent themes, the weight is placed more on the voices of the participants than of the researcher.

Thus, Luborsky's (1994) definitions of themes and topics served as the basis for conducting thematic analysis for this study. A theme is a generalized statement made by the participants that reflect their personal and cultural beliefs, attitudes, values, or sentiments. Themes are used to draw relationships and unify separate experiences into an "overarching meaning" (Luborsky, 1994, p. 195). To identify themes, I used Luborsky's (1994) suggested approaches: (1) finding repeated or frequently occurring statements, and (2) seeking statements that are marked as being particularly meaningful and significant to the participant. A topic is an area of concern that participants and the researcher jointly identify that summarizes the content. A topic can also be prompted by the interview questions and the participants' responses. All together, themes and topics are used to form meaningful interpretations of the participants' experiences.

## **2.6 Anonymity**

Due to the nature of this qualitative research design in collecting participants' personal experiences using interviews, there was a risk that participants could unintentionally identify themselves through the data collected. The field of speech-language pathology is relatively small with few practitioners who have experience working with Aboriginal clients with ABI. In such circumstances, the information that participants choose to reveal may make them recognizable to

someone who is familiar with them, even if they are made anonymous, particularly if it is linked in any way to the service area in which they work. Therefore, considerations of anonymity were given the highest priority. Each participant was anonymized through two randomly assigned unique identifying codes. The first numeric code for each participant was used in the results section describing the context of service delivery. The second code assigned to each participant was a letter that was randomly associated with the number. This alphabet code was used in the results section describing the thematic analysis. In addition, to further provide anonymity, all pronouns referring to participants are feminine and all pronouns referring to patients are masculine, while 'man' or 'woman' (referring to patients in participants' quotes) has been changed to 'person' throughout.

Prior to each interview, procedures for maintaining confidentiality and anonymity were clearly and carefully explained to all participants. Any identifying information, such as specific place names and agencies, were removed from the data. Furthermore, necessary precautions were taken to maintain client confidentiality. Participants were not asked to provide any specific client information; however, in the event that a participant provided details regarding client information that could potentially identify that individual to someone who already knows him or her, provision was made to digitally edit the information out of the recording itself. This procedure, however, was not required.

## Chapter 3: Results

To explore speech-language pathologists' experiences in working with Aboriginal adults with an acquired communication disorder resulting from brain injury, the following research questions were posed:

- (1) How do the participants characterize their overall experiences with working with Aboriginal clients with ABI? In particular, what challenges, barriers, and/or facilitators do they encounter regarding referral, assessment, treatment, discharge, working with Aboriginal support workers, team meetings, and community services?
- (2) How do the participants provide culturally safe care for their Aboriginal clients? Specifically, what have they done to prepare or educate themselves to implement culturally safe care in their clinical practice?

A wide range of perspectives was captured across the interviews to address these questions, which also highlighted the diversity in speech-language pathologists' experiences in working with Aboriginal adults with ABI in British Columbia. From the interview data, four topics (i.e., areas of concern that summarize the content) were identified: (1) participants described the service delivery model for providing services to adults within their health care setting; (2) within the context of service delivery, participants emphasized working with patients and families; (3) participants acknowledged issues that they considered to be specific to Aboriginal peoples; and (4) participants discussed their understandings of cultural safety, as prompted by one of the interview questions.

Thus, the results section is presented and organized by these four topics. The first topic is an overview of service delivery contexts in practice for both Aboriginal and non-Aboriginal adults across British Columbia, including a description of the relative proportions of Aboriginal



clients seen by the different participants. Because the first topic is fully descriptive, thematic analysis was not applicable. For the remaining topics, thematic analysis was used to identify themes (i.e., reflections of participants' personal and cultural beliefs, attitudes, values, or sentiments) that emerged from the participants' perspectives. Each theme is introduced by a representative quote in its respective section that captures the essence of the theme. The second topic describes two themes that arose from participants' experiences in providing services to adults (i.e., Aboriginal and non-Aboriginal) with ABI: (1) building relationships with patients, and (2) family and community support. Particularly for the first and second topic, participants did not always specifically consistently specify whether the patient was Aboriginal or non-Aboriginal. However, issues for Aboriginal patients became particularly nuanced as the interviews progressed, as illustrated in the third and fourth topic. In the third topic, participants highlighted specific issues related to working with the Aboriginal population with three themes emerging from the data: (1) working with issues related to endangered languages of Aboriginal communities, as well as Aboriginal culture and identity, (2) an increase in awareness of colonial impacts in health care, and (3) a step towards holistic practice. Finally, the fourth topic explores cultural competency and cultural safety as a critical component of working with Aboriginal peoples. Two themes emerged from the data: (1) participants' feelings of uncertainty, and (2) the role of relationships in providing culturally safe care.

### **3.1 Mapping the Territory: Service Delivery for Adults in British Columbia**

During the interviews, all the participants described experiences that center heavily on service delivery in their practice, thus setting a context for providing service to both Aboriginal and non-Aboriginal patients. A description of the type of service delivery within each of the participants' facilities is included to help illustrate various issues that participants have

personally encountered. The speech-language pathology service delivery model ranged from providing services to adults with ABI in the acute to inpatient rehabilitative settings, the acute including various units such as the Intensive Care Unit; Emergency Room; and the medical, surgical, and stroke wards. Hospitals in northern and interior areas of British Columbia and on Vancouver Island provide services to smaller communities situated in rural and remote areas; however, participants explained that it is common for patients to be transferred to bigger hospitals located in Metro Vancouver to receive services that are not offered at their local hospital. Most of the participants also reported access to dedicated Aboriginal services in their facility, such as an Aboriginal healing room or Aboriginal support workers.

Participants working in acute settings reported that their general caseload comprises patients (i.e., both Aboriginal and non-Aboriginal patients) primarily with stroke or TBI; however, two participants mentioned that their caseload and priorities of care tend to be more oriented towards dysphagia management. Participants working in an inpatient rehabilitative hospital reported that they receive clients with both swallowing and communication impairments. In addition, participants shared stories extending beyond language impairments and also included, for example, dysphagia and dysarthria.

In terms of the number of Aboriginal patients that participants worked with in their respective facilities, the majority of the participants reported that there is generally a small number of Aboriginal patients. One participant commented that she sees Aboriginal patients “on and off” (Participant 5, lines 10-11) in her caseload, while another acknowledged, “there’s not quite as many as I thought actually” (Participant 1, line 28). Further, two participants provided a rough estimate of the number of Aboriginal patients they see on their caseload, and both their responses were approximately between 10-20% (Participant 3, line 34; Participant 4, line 60).

Diversity in background experiences with working with Aboriginal adults with ABI was also evident across participants. In terms of working with Aboriginal clients with ABI, one participant remarked “not very many though, I could probably count on one hand” (Participant 6, lines 8-9), while another participant noted that she has worked with “quite a few” (Participant 7, line 6). For another participant, since transferring to a hospital that has a particular focus on the Aboriginal population, she commented that she has seen Aboriginal patients more consistently than in her previous work setting. All of the participants reported that most of the Aboriginal patients they have worked with come from rural and/or remote communities. In addition, the majority of participants see their patients in an inpatient setting within their facilities.

Challenges in working in acute care were noted by some of the participants. Because dysphagia tends to take priority in acute care, patients with communication impairments as a result of brain injury may get “missed” (Participant 1, line 496) and clinicians only “hear it about it afterwards” (Participant 1, line 496-497). One participant remarked, “we usually try to do as much as we can in a brief period, and then when they’re safe to go home, they go home” (Participant 4, lines 314-315). When asked further about follow-up services for patients from rural and remote communities, one participant commented “we don't know what happens to them in their communities” (Participant 7, line 705). With similar sentiments regarding the fast-paced nature of acute care as those of the previous participants, this participant reflected on the following:

That one has stayed with me, and a lot of it is like, that’s acute care to me that’s hard to work in, is you find out intimate details of a person’s life and then never see them again. And never hear what happens. There’s not necessarily any follow through. (Participant 2, line 349-352)

Several participants also voiced concerns regarding the lack of or limited outpatient and follow-up services, including speech-language pathology services, in northern, interior, and island rural and remote communities. Two participants noted that there are no outpatient services in their area, with one remarking, “we don’t have a lot going for outpatient services or community type rehab services” (Participant 1, lines 543-544). Another participant from another region, who has a dedicated position in both inpatient and outpatient services in her facility, commented that the time for outpatient services is taken away when the caseload on acute is “exceptionally busy” (Participant 3, line 47). Additionally, delayed discharges may occur for patients who are from rural and remote areas. For instance, the health care team may delay discharge due to scheduling conflicts, such as arranging for an air ambulance to transport the patient back home, or due to challenges in finding appropriate community services to ensure that patients return home with services they need.

Participants made further comments on the challenges that they have encountered in trying to refer their patients onward for further speech and language therapy, while outlining various strategies they try to take advantage of. For example, one participant remarked that patients “try to cope as best as they can, maybe they’ll have nursing check in on them, or maybe they’re living in a community that has outpatient OT [occupational therapy], outpatient PT [physical therapy], but they’re not going to get any speech” (Participant 4, lines 303-305). One participant reported making use of a health support center located in her patient’s home community that provides support in activities of daily living, such as “rides into the city for therapy and organiz[ation of] things for house cleaners” (Participant 6, lines 106-107); however, the center does not offer any speech therapy. As a result, Aboriginal patients from rural and remote communities with limited services may have to resort to private therapy that is “hopefully

funded by the band” (Participant 6, line 112). With limited speech-language pathology services available upon a patient’s return home, two participants commented on maximizing support such as providing “lots of family training” (Participant 2, line 617) or “relying on dietitian and nursing staff” (Participant 7, line 299) for dysphagia management.

Overall, it appears that the lack of health services in general in northern, interior, and island remote and rural communities brings patients to urban areas such as Vancouver, where there are relatively more available and accessible resources. Two participants commented on working with patients who were originally from remote communities and relocated to urban areas to receive services that they would not have access to otherwise, as exemplified in the following comment:

There’s one person I’m working with right now who is actually considering moving down here from the Yukon because he’s getting older, he has multiple medical problems now, and he feels it’s easier to access medical services. So that’s his main reason for moving down here. (Participant 2, lines 96-99)

On the subject of the lack of or limited outpatient services, several participants noted resources that are available, such as Connect and Telehealth, and discussed their advantages and disadvantages. Connect (n.d.), an outpatient program for people living with brain injury, is one of few resources available to brain injured patients throughout the province. However, the program is only offered in two locations. The participant who made the earlier comment about the lack of outpatient services in her area is familiar with Connect and explained that even the facility located nearest to her area may be too far for her patients from northern rural and remote communities to access:

Even if they come from [place], it's about eight hours away. So families find it's not really feasible for them to be visiting all the time. But if they are coming outside of [place], even our most northern centers are 14 hours from here, then another eight hours on top of that. It's a long way. It's a really long way. So it'll be more manageable I think, for families if there were something closer by. (Participant 1, lines 961-968)

Telehealth utilizes videoconferencing technology to connect with patients living in remote communities. One participant expressed that Telehealth is “advocated for” (Participant 3, line 94) within her health authority and another participant commented that it helps to “decrease the distance” (Participant 5, line 142). When asked about the benefits of using Telehealth, one participant explained:

Unfortunately we're so few and far between as speech pathologists working with adult neurogenic disorders, that travel time takes away from clinical time and so being able to have the patient access us through Telehealth can help with that. (Participant 3, lines 95-97)

One participant mentioned using Telehealth to provide follow-up services for her patients in rural and remote communities. Patients are able to access Telehealth if they have the equipment set up in their local facility to connect with a speech-language pathologist. The two participants who have experience providing Telehealth services reported that they have conducted clinical swallowing assessments, communication consultation, assessment, and treatment, as well as providing supported conversation and dysphagia training with a family member. Although Telehealth does deviate from the conventional face-to-face and hands-on interaction with the patient, both participants provided positive feedback, as expressed by one participant in the following comment: “It's actually been surprisingly good. Not that it wouldn't be. But we've

been quite reinforced ourselves by the positive interactions that we've created with the Telehealth" (Participant 5, lines 160-165).

### **3.2 Working with Patients and Families**

Within the context of discussing service delivery issues, participants' stories tended to focus on working with patients and families to help promote positive health encounters. Two themes emerged from participants' data: (1) "Listening to them with their beliefs": Building relationships with patients, and (2) "A huge effect": Family and community support. The first theme captures the diversity in participants' perspectives of building relationships within their health care setting, which includes managing brain injury impairments, learning about the patient's culture and background to tailor therapy to the patient's interest, and acknowledging potential power imbalances. The second theme illustrates various supports for patients, namely family and community, that play an integral part to their health and well-being.

#### **3.2.1 "Listening to them with their beliefs": Building relationships with patients**

*"So, kind of listening to them with their beliefs, and their spiritual beliefs, and their philosophies. And you get some really interesting answers, for sure, and very enlightening."*

—Participant B (lines 184-186)

Building relationships with patients was discussed by the majority of participants; however, participants varied greatly in what they emphasized. In general, participants felt that building relationships helped to establish trust and to create a safe and positive environment. Some participants believed that building relationships allowed them to learn more about their patients' culture and background to help tailor therapy to their patients' interests. Additionally,

participants were also aware of power imbalances, particularly in working with Aboriginal patients.

Two participants acknowledged that building rapport was especially important for any patient with brain injury, because the nature of their disabilities may include inconsistencies in managing appointments, as well as a “lack of insight” (Participant E, lines 259-260) and “motivation” (Participant E, line 260). As a result, one participant expressed that health care professionals need to compensate for their patient’s disabilities, as “you don’t want to say three strikes you’re out” (Participant E, line 257). She expressed that clinicians need to be “firm” (Participant E, line 265) and “have some type of verbal contract or agreement” (Participant E, lines 265-266) to ensure that the patient is able to consistently receive therapy services.

Participants also discussed learning about their patient’s culture as another way to build relationships. Discovering in-depth details about the patient’s background and what their community looks like help clinicians tailor therapy for their patients, particularly for clinicians who are unfamiliar with their patient’s environment. One participant acknowledged that “this [example of traditional hunting practices] is not part of my reality” (Participant C, line 141) and another participant further elaborated a similar sentiment with the following comment: “They talk about all these places that they come from and I’ve never been up north. So to talk to them about it and sort of incorporate that into our therapy” (Participant G, line 113-117). Thus, building rapport can also increase buy-in for therapy, as the same participant reflected, “sometimes the buy-in, I found especially with First Nations people, often wasn’t there, in terms of - sort of straight up regular pen and paper kind of rehab” (Participant G, lines 518-520).

Two participants were aware of potential power imbalances in working with Aboriginal patients, a theme that relates to cultural safety discussed in section 3.4. One participant



acknowledged that there may be a sense of “I’m the expert and I’m going to tell you what’s wrong with you and you better listen to me and do as I say” (Participant B, lines 177-178).

Another participant, who also expressed similar concerns of clinicians being seen as the “expert,” has worked with a few patients who were “very quiet” (Participant A, line 551). She found it challenging to obtain information from certain patients, further elaborating her encounters with the following description:

They’re listening to everything. They ask for my opinion. But then when I flipped the tables because that’s what I tend to do with patients, now I want to hear what their goals are, what they think about what I’ve said, what they want for a treatment plan.

(Participant A, lines 549-553)

The same participant cited an example of working with an Aboriginal patient with severe dysphagia, who appeared to understand the diet recommendations and risks but, she later learned, was not following her recommendations. The participant, reflecting on what she felt was minimal communication between her and the patient, acknowledged her difficulty in understanding the reasons for this, as expressed in the following comment:

I could never figure out, how much it was cultural, he just didn’t say to me. How much of it was personality, that that’s the kind of [person] he is. How much of it was a brain injury, where he just really wasn’t understanding a lot of what I was saying. And I could never tease any of that out. (Participant A, lines 570-575)

While sharing insights into how power imbalances play a factor in building a positive working relationship, a theme that is also explored further in the discussion of cultural safety (see section 3.4), one participant’s comments revealed her efforts in trying to move away from a hierarchical clinician-patient relationship to a more positive and productive working partnership

between the clinician and patient. This participant explained that, instead of approaching Aboriginal patients with the sense of “I’m the expert,” she has found it important to identify strategies for creating better health care encounters and minimizing disrespectful relationships by listening:

I learned that it’s important to ask them, what do you think is causing your difficulty? Or what do you think would help you? Rather than, this is what your problem is and this is what you have to do to get better. So, kind of listening to them with their beliefs, and their spiritual beliefs, and their philosophies. And you get some really interesting answers, for sure, and very enlightening. (Participant B, lines 181-186)

### **3.2.2 “A huge effect”: Family and community support**

*“The importance of family and extended family and community and their band or their nation makes a huge effect.”*

—Participant B (lines 324-325)

The value of a patient’s support system resonated throughout the interviews. In particular, five participants reflected on the valuable contribution that support from family and community can have during a patient’s hospital stay. This theme highlights the various forms patient support systems can take. As one participant expressed, “the importance of family and extended family and community and their band or their nation makes a huge effect” (Participant B, lines 324-325). Especially for patients who are “taken out of their community” (Participant G, lines 431-432) to relocate to a new and unfamiliar environment, they may “feel like there’s nothing there to make them feel at home” (Participant G, lines 435-436) as they lose their direct support and “feeling of belonging” (Participant B, line 326), thus resulting in a sense of isolation. Another participant remarked: “Family support is enormous and many, many family members involved

with any particular patient, which is lovely, especially around adequate stimulation in the hospital. So there's often a family member present anytime during the day" (Participant E, lines 60-63).

Participants highlighted facilitators and challenges they have encountered with family and community support. One participant shared a story about an Aboriginal patient in his twenties who was admitted to the hospital with a severe TBI and needed to continue rehabilitative services. As a result, the family moved to an area where the patient was able to access and receive therapy that he would not have otherwise received if had he stayed in his home community. The participant reported, "families don't generally move here" (Participant D, line 694); however, this patient's family "really changed their life around to support him" (Participant D, line 96). The participant explained that the patient's recovery was a long process, given that the patient was in the hospital for over a year and the Insurance Corporation of British Columbia (ICBC) was also involved with the patient's case. Regardless, the participant's story illustrated the family's sense of commitment and responsibility to the patient, as expressed in the following comment: "They were really amazing. They were a super supportive family in that they just ran with anything you gave them, which was great" (Participant D, lines 663-665).

The same participant then paired her previous story with another story where the health care team encountered challenges in finding appropriate support for a patient who was admitted with a TBI and had a background of substance-related issues. This patient was in need of continuing rehabilitative services; however, the family "couldn't really support him in his rehab, things we were asking them to do, or even just where he could live" (Participant D, line 246-247). The patient's case was also further complicated by police involvement. The participant reported that upon discharge the patient was transferred to a drug and alcohol centre until a space

became available at the rehabilitative centre for brain-injured patients. The participant reflected on the several complicating factors, resulting in the team taking precautionary measures to ensure that the patient could return to a safe environment: “It was interesting. And the whole community, everyone was kind of on board. His family was on board with it. There was nothing else they could do” (Participant D, lines 319-321).

Another participant shared stories highlighting positive and negative aspects around patient advocacy from family and community, as described by one participant who worked with a patient with global aphasia and was in need of speech-language pathology services:

It started with the physician. He recognized [that the patient’s] hierarchy in the community was very, very high. So I think he was feeling pressure from the family and the community to advocate for him to come down to receive speech pathology. But also, he himself strongly believed that [the patient] could benefit from it. We set up some Telehealth meetings before he came down and there were eight or nine people in on the Telehealth meeting, which you often don’t see all these care aides and so on that wanted to support his strategies around communication and deliberately involve - it’s not because they have to be there for work, it’s because they wanted to be there. (Participant E, lines 75-83)

The same participant also recognized that the quality of family support can be affected by family dynamics and status (Participant E, line 139), with different family members offering different opinions on how the patient’s care should be managed. She experienced a challenge in providing consistent therapy for a patient who was diagnosed with severe dysarthria, apraxia, and aphasia, as well as concomitant cognitive deficits, who was regarded as a “real father figure” (Participant E, line 224) and well-respected in his family. The patient did not receive consistent speech-

language pathology services, because, following the patient's wishes, the family moved “from home to home in all of these remote areas” (Participant E, line 145). Clarifying that the following situation was “not specific to aboriginal at all” (Participant E, line 211), the participant acknowledged that some families have “the best of intentions but for whatever reason, they’re not able to follow through with what our verbal contract or agreement is around treatment services” (Participant E, lines 212-214).

While families do differ, another participant expressed the opinion that big family support is more characteristic of Aboriginal peoples than other groups based on the patients she has worked with, as illustrated in the following example:

So, often then you’ll just see huge gathered family members, band members, that kind of support, their friends, and their relatives, if possible. And you don’t really see that with other communities. You might have your mom, and your dad, and your brother and sister. But with them, they’ve got 30 people showing up. And so you have everyone else over and you can’t have that many people in there [i.e., the patient's room]. So then, they’re all hanging out in the hallway, and there’s [a volunteer-operated coffee cart], like a trolley practically, going by trying to support these people that are there for their family members. It’s just such a different cultural reality. (Participant B, line 333-347)

Furthermore, when asked about her experience working with an extensive support system, the same participant recounted an example of balancing between the various family members that were all present simultaneously:

It’s interesting because I can recall walking into a room, patient’s in bed, and I’m there doing a swallowing assessment, and there’s granny, aunts and uncles, cousins, their children, their grandchildren, babies, toddlers. And you’re like, okay, I’m here to do a

swallowing assessment and they all want to know what's going on. So you're trying to figure out who you're carrying the message to. It's really neat. It can be overwhelming, because there's all these people. But they're there for their loved one. (Participant B, lines 356-368)

Despite the overwhelming experience, the same participant reflected on maintaining a positive and professional demeanor: "It does feel like you're on stage. And you're doing a swallowing assessment and all these people are watching you. But you've just got to do your best" (Participant B, lines 383-385).

Finally, one participant specifically mentioned the positive contribution that community support made for her patient who relocated to an urban centre to receive outpatient therapy. The patient was able to attend therapy sessions at the rehabilitative facility by "staying at a First Nations housing that was found by their reserve" (Participant G, lines 73-74). Recognizing that the patient had strong ties to his culture and community at large, the patient was able to participate in First Nations community centers that were not only meaningful for his recovery process, but also allowed him to stay connected to his culture while being apart from his home community:

There are centers around where he shared some of his work, shared his stories. So he had that community around him to support him through this thing too, so that was kind of neat to hear about and to also learn that there are support systems out there for people who need it. (Participant G, lines 407-410)

### **3.3 Acknowledgment of Issues Related to Aboriginal Peoples**

As discussed in the previous sections, service delivery frameworks can impact both Aboriginal and non-Aboriginal populations living in either rural, remote, or urban areas. This

section focuses on participants' understandings and experiences that they have identified as concerns related to working with Aboriginal peoples. Three main themes emerged from the data: (1) participants' experiences related to Aboriginal endangered languages, culture, and identity; (2) growing awareness of the impacts of colonization; and (3) a move towards holistic practice in health care.

### **3.3.1 “It felt like a whole community was losing something”: Language, culture, and identity**

*“I’ve never had such a huge weight attached to it like I’ve had with other people. There’s always a personal weight attached to something like that. And you can start to learn and feel for that person and that family’s stress and sadness around it. But I’ve never had one where it felt like a whole community was losing something.”*

—Participant A (lines 234-240)

This theme focuses on participants' experiences with endangered languages, culture, and identity in relation to working with Aboriginal adults with ABI. Participants' experiences that exemplify this theme include working with patients who are elders with an important role in their respective communities, and working with patients who are among the last speakers of an endangered language. Participants' reflections on the role of possible culturally-related language patterns in their patients' communication also contributed to this theme.

Two participants commented on their patients' status within their community, acknowledging their patients' role in the community and its relevance for speech-language pathology services. One participant worked with a patient with global aphasia who was in need of speech-language pathology services. This participant reported that the patient's status in the community was “very, very high” (Participant E, line 76), thus contributing to his successful

relocation to receive outpatient speech-language pathology services through family and community advocacy. Because elders play an important role in their community where they are often seen as leaders who pass on oral traditions, one participant suggested that they may place more value on oral communication, as expressed in the following:

I get the sense that lots of the patients I've worked with, including this most recent one, value the quality of their speech more than a lot of other patients that I've worked with. Because there's this oral tradition. Because they quite often speak in public. Because they are leaders in front of groups of younger people. And that's just in my head, I haven't heard that from them specifically. (Participant A, lines 274-279)

Several participants mentioned working with elders from communities where their language is critically endangered. In trying to learn about the patient's background, the participant reported that the patient shared some words from her native language with her. However the participant reported that when she asked the patient if he speaks the language, the patient responded, "it hadn't been passed down" (Participant G, line 618). However, the patient mentioned that the grandson was learning the language.

Another participant had the opportunity to work with an elder who was the last native speaker of the heritage and was diagnosed with progressive dysarthria. The participant described the experience as "heart wrenching" (Participant A, line 200) with the following reflection:

I felt this huge sense of responsibility for this person who I was going to assess for motor speech, whose speech is declining, and who plays such an important role, not only in his community, but to me in the larger community of dying languages. (Participant A, lines 218-223)



Unfortunately, the participant was only able to work with the elder a few times, which mostly consisted of speech strategies to manage the progressive dysarthria before discharge. However, while the same participant was “deeply affected” (Participant A, line 259) by the patient’s case, she reflected how other health care professionals may not have felt the same sentiment: “That was part of the experience of working with that patient, is that nobody else really seemed to grasp the importance, or the significance, or the poetic sadness of the situation” (Participant A, lines 254-256).

Several participants mentioned possible cultural differences in communication that they observed while working with Aboriginal adults with ABI. While acknowledging aspects of non-verbal communication, such as decreased eye contact and more silence during conversation, some participants reflected on the difficulty in differentiating between whether these aspects stemmed from a cultural factor or a language communication deficit from brain injury. In regard to speech, one participant commented on dialectal differences that may affect a clinician’s judgment of an Aboriginal patient’s speech at baseline, as expressed by the following comment:

Sometimes talking about that eye contact and talking about some of the phonology too. Sometimes you might think that needs to be worked on, but it could just be culture, language, or dialectal. It’s part of just a culturally language-related thing. (Participant G, lines 905-909)

While working with a patient who was diagnosed with mild dysarthria, another participant reported that the patient appeared quite unhappy with his speech. The participant noticed characteristics such as slow rate, flat prosody, imprecise articulation; however, the participant commented on the challenge in knowing whether the speech differences were part of the patient’s cultural background or attributable to the patient’s mild dysarthria:

It's been an interesting experience because he's the first patient I've worked with who seems aware of these cultural differences. And me attributing all of those speech differences to him being an Aboriginal person, it's kind of iffy because I couldn't say that all of his speech patterns are the same as another First Nations person I've worked with. Because they're probably not. He's from [place 1], others are from [place 2], others are from [place 3]. And I don't know exactly what those patterns are. (Participant A, lines 173-177)

Similarly, another participant acknowledged different communication styles and commented on using speech strategies to accommodate her patients:

I think even just speech pattern wise, I'm being a real speech path here, is the rate of speech is different, which I'm noticing. So I can't help but reflect that pace and tone of conversation and making sure that I'm doing a lot of listening and not just verbally directing all the time. (Participant E, lines 499-508)

### **3.3.2 “He’s a survivor from residential schools”: Growing awareness of impacts from colonization in health care**

*“What struck me most at first, is that he’s a survivor from residential schools.”*

—Participant C (lines 34-36)

The theme of growing awareness of the impacts from colonialism in health care maps the participants' experiences, while highlighting their personal reflections, in working with Aboriginal patients with ABI who are living with direct and indirect effects of colonization. Experiences related to the direct impact of colonization include those of participants working with patients who are survivors of residential school. Indirect impacts include underlying and unresolved issues as a result of colonization.

One participant illustrated the process of passing on fear of Indian hospitals from one generation to the next with the following comment:

If you say you have had grandparents who have experienced that, they're going to share that story with their child. And then that parent is going to share with their grandchildren and often grandchildren are admitted to the hospital and were like, 'oh my gosh, I'm scared of these white people's hospitals.' (Participant B, lines 241-244)

Two participants shared their experiences in working with survivors of residential school who were willing to share their stories about residential school with their respective clinicians. One participant acknowledged the value of learning more about the deeply rooted impacts of colonialism in her patient's life, as expressed by her reflection: "Having a little bit of background helps. You relate to the client as well and just to kind of - some of the horrible things that some of them endured. And being at the [facility], do they feel like they're in that setting again" (Participant G, lines 718-721)? While this participant's patient reported no concerns in receiving therapy, another participant worked with a residential school survivor who was not receptive to group therapy. As a result, the participant immediately discontinued group therapy sessions, as described in the following comment:

I had asked him if he wanted to participate because usually our people with aphasia will participate in group treatment also. And he was a bit hesitant. He was communicating to me, 'I've been alone for many years and I'm not a group person,' but he was willing to try it. So one day, I took him to the group. But he had a very strong emotional reaction, it almost looked like he was getting images or sounds, kind of like - I wouldn't diagnose him, but it looked to me like almost PTSD. And then we left. And then, it was, okay,

we're not doing this anymore. So we're just doing one-on-one therapy, we're not exploring the group thing. (Participant C, lines 540-550)

A few of the participants also discussed the complexities in handling issues related to alcohol, drug, mental health, and abuse while working with several Aboriginal patients. In describing her experience in learning about her patient's background of mental health and domestic abuse issues, one participant used the term "difficult" (Participant G, line 153). Although the participant acknowledged "it's nice that he feels like he can share those stories with me as well, and be open about it" (Participant G, lines 156-157), the difficulty appears to stem from the discomfort in addressing the topic, as shown in the following comment:

I think a lot of it - we try to sort of talk about it, acknowledge it, and then kind of move on to more of the speech, like working on our dysphagia and dysarthria exercises, because again, I don't feel comfortable as a counselor. And especially with this sort of topic, because it's been long-standing, it's been years and years of it. (Participant G, lines 359-365)

Relative to the above, two of the participants have witnessed negative stereotypes, prejudice, and discrimination in the health care setting. One participant described a case where a patient who was admitted into the hospital was also being investigated for a crime. She reported that the staff had "less than professional attitudes towards [the patient]" (Participant B, lines 90-91) reflecting on "racist attitudes definitely going on in the hospital setting" (Participant B, line 99) because "of the situation and [the patient] being First Nations" (Participant B, line 98). The same participant reflected on the following possible outcome of negatively stereotyping from health care staff:

When you just walk in there and you're just treating a patient and you just work with them and you just have to leave all that kind of stigma and prejudice at the door. It did affect - because I could see how he was possibly getting a different level of care or attention. I think people possibly wrote him off because of his situation and what he did or didn't do. (Participant B, lines 107-112)

Similarly, this participant became aware of the negative use of the "First Nations" label in her work setting. She shared the same sentiment as the previous participant in how negative stereotyping affects a patient's level of care: "I would notice it being used sometimes in rounds as a dismissive term. I can't say for sure that they ended up receiving different care because of it, but of course that happens as soon as you throw out a term that has negative connotations" (Participant A, lines 907-913). She described how stereotyping by other health professionals affected her personally:

That's been a real source of discomfort for me in working at [hospital], is medical team members throwing out terms like First Nations as a way of easily categorizing somebody who might be a difficult patient or who they think is, I don't know what some of the assumptions are, not going to follow through a medical plan or that sort of thing. I hope that doesn't stick around forever. (Participant A, lines 919-923)

### 3.3.3 “It’s becoming more of the norm”: Move towards holistic practice

*“Even where I work right now, we have an Aboriginal [Support Worker]<sup>3</sup>. So, I think it’s great, it’s becoming more of the norm.”*

—Participant B (lines 478-479)

While the previous section explored issues such as negative stereotyping of Aboriginal peoples, this section moves towards the notion of incorporating holistic practice that is beginning to be more accepted in health care settings. Many of the participants were aware of services that are dedicated to the Aboriginal population and recognized the role of Aboriginal support workers in helping to connect the patient to appropriate resources. In addition, one participant commented on traditional medicines that were integrated into health management. The inclusion of dedicated Aboriginal services and traditional medicines is a step towards a holistic practice, as one participant remarked: “It’s nice to just be aware of that because it’s really easy to get caught up in the kind of traditional medical model” (Participant D, lines 802-803). One participant shared an experience where the use of traditional medicines was integrated into the patient’s health management: “It was homemade, and he’s like, oh, smell it, and my family made it for me, and so that went okay with the doctor. They were happy - using it for massage for the hemiparesis” (Participant G, lines 775-777).

Interdisciplinary teams are often involved in a patient’s care, and participants noted two groups of health care professionals in particular, social workers and Aboriginal support workers,

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<sup>3</sup> The term *Aboriginal Support Worker* is used to encompass the specific titles used within each of BC’s health authorities in order to further protect the anonymity of participants. See Appendix B for each health authority’s specific terminology within this category.

whom they find particularly helpful in managing the care of patients with an Aboriginal background. The responsibilities of social workers and Aboriginal support workers often included liaising with the Aboriginal bands for resources, such as funding. Three of the participants, who have had opportunities to work with their designated Aboriginal support workers, described positive experiences in working with Aboriginal support workers and reflected on aspects of holism that Aboriginal support workers contribute to their health care environment.

The participant who commented on the inclusion of dedicated Aboriginal services as “becoming more of the norm” expanded further by providing an example of the Aboriginal support worker’s contribution to team meetings: “She would talk a lot about the importance of family connections and the culture and what it’s like of that person back home. And what supports, what troubles they have. So it’s good because then there’s educating the rest of the team” (Participant B, lines 231-235). Another participant took initiative to converse and connect with the Aboriginal support worker in her facility in order to learn more about her patient and her patient’s family, as illustrated in the following comment:

I find when I go to her office to connect about a particular patient, it’s usually a very lengthy discussion. And there’s a lot of background provided, not only about the patient, but the patient’s family as well. There’s always that lengthy story telling history involved with each of the patient, which is great because it gives me much bigger picture around their communication needs. It’s been very positive and all the staff knows if an Aboriginal patient comes in that they’ll automatically let the [Aboriginal Support Worker] know. And usually that [worker] knows the patient already and the family dynamics, which can really help. (Participant E, lines 304-314)

Four of the participants reported not having had any opportunities to work with their respective Aboriginal support workers. One participant commented that she finds it difficult to “cross paths” (Participant F, line 294) with the Aboriginal support worker, while another participant reflected on the potential benefits of including her facility’s Aboriginal support worker in her practice:

It’d be interesting to know exactly and how we might be able to include them better.

Because I’m thinking just for this particular client, I think it’d probably be really helpful for this person to meet with me and know what’s helpful communication-wise with my client. So that makes me think, oh, maybe I should seek out this person. (Participant C, lines 309-314)

Interestingly, of the participants who have not worked with their respective Aboriginal support workers, three acknowledged that the social worker is someone who works closely with the Aboriginal support worker. One participant in particular reported that she actively seeks out her social worker as a resource for working with Aboriginal patients, because she feels that they have “better knowledge of both First Nations issues related to health care and of supports that are available or are in place already” (Participant A, lines 325-327). While there is diversity in participants’ experiences in working with dedicated Aboriginal services, this theme captures the growing acceptance of moving towards holism through participants’ reflection and awareness of their experiences with holistic practice.

### **3.4 Cultural Competency and Cultural Safety**

Within this topic of cultural competency and cultural safety, two themes emerged: (1) “That’s a good question”: Uncertainty, and (2) “Listening to their perspectives”: Roles of relationships in cultural safety. The first theme illustrates participants’ self-awareness of their



skills in cultural competency and limited knowledge in providing culturally safe care to Aboriginal peoples, thus resulting in discomfort for some participants. Diversity in understandings of cultural safety and educational background were also captured in the first theme. The second theme highlights the role of relationships with both patients and families as a component of cultural safety. In particular, participants acknowledged the importance of building rapport with their patients, as well as connecting with family members to create a culturally safe environment in their practice.

### **3.4.1 “That’s a good question”: Uncertainty**

*“Ah, that’s a good question.”*

—Participant D (line 736)

Cultural safety was discussed as a result of the researcher asking participants directly to share their perspectives on culturally safe care and their experiences in implementing cultural safety in their practice. Comments such as the quote shown above were a common response amongst the participants when asked about their understanding of cultural safety and also in response to whether they check in with their patients to know if they are providing a culturally safe environment. Most of the participants reported that they do not specifically check in with their patients, while one of participants reported she only does so in certain circumstances:

Only when I feel like there is possible friction between what I’m trying to do and what they want. Or between what the team is deciding and what they are doing. So I wouldn’t say I do it on a routine basis. I’d say only when I start to feel uncomfortable. Or I noticed that maybe there’s something uncomfortable for the patient. (Participant A, lines 813-818)

Nonetheless, a diversity in participants' response and perspectives of cultural safety was captured, ranging from being aware of "cultural societal differences and expectations" (Participant D, line 727) and "differences in interactional style and differences in reaction and differences in communication" (Participant A, line 756) to considering "any sensitivities of another culture" (Participant F, line 321), approaching patients with "respect and empathy" (Participant B, line 437), and "being sensitive around the residential schools" (Participant E, line 395).

Also within the topic of cultural safety, several participants demonstrated self-awareness of their level of skills and knowledge in working with Aboriginal peoples. Two participants reported feeling "ill-equipped" (Participant A, line 695; Participant E, line 653), while another participant feels that she is "still not necessarily aware of everything, still a bit of a learning curve" (Participant D, line 727-728). One participant remarked "I'm not sure if I'm really well trained to know what that is" (Participant C, lines 365-366). While this participant had attended a cultural safety workshop, she reflected on the difficulty in knowing what the specific approaches are:

I always find this a little bit hard though, I mean, it's almost like it's telling us to be kind of really open and listening to what people need and things like that. But it still doesn't give us answers of what to do. (Participant C, lines 415-417)

Further, another participant reflected on her discomfort in responding to survivors of residential school who share their stories: "I always think, ah, I should really delve into that a little bit more. Not with the patient, but in terms of feeling more comfortable, I think, for me, and how to deal with that" (Participant E, lines 404-406). Similarly, one participant revealed a personal "lack of comfort in addressing First Nations specific issues" (Participant A, line 431-

432), a topic that repeatedly resonated throughout her interview. To elaborate her source of discomfort, she explains: “Because I don’t necessarily know what those are still and are there some that are First Nations specific, or is it just really one specific context for a person” (Participant A, lines 432-439). The same participant also mentioned her “anxiety around doing something inappropriate” (Participant A, lines 682-683), elaborating further in the following comment: “I feel like I’m constantly approaching it by managing my own anxieties around the situation, rather than trying to think of what their experience of the situation is” (Participant A, lines 683-685). The participant then refocused to the perspective of the patient and reflected on whether the health care team is consistently providing culturally safe care:

The tables are only flipped when I hear the team start talking about behaviour or I start noticing behaviour that I feel that is strange or atypical. And that’s when I start to wonder, oh wait, have we been providing care in a way that they understand, that they’re comfortable with, that they want. (Participant A, lines 686-689)

Education in cultural safety and approaches to working with the Aboriginal peoples also varied from participant to participant. Several participants reported having taken formal courses or workshops on cultural safety or Aboriginal history, while others relied more on personal experiences and continuing efforts to converse with health care professionals who they feel are better equipped to working with Aboriginal peoples, such as social workers and Aboriginal support workers. Several participants commented on the importance of education, as one expressed, “having the education regarding the history of our local Aboriginal folks here and the treatment and the culture, it’s eye opening” (Participant B, lines 382-384). There was also a general interest in participating in continuing education on cultural safety from several of the

participants. However, one participant also illustrated the competing demands for learning that she faces as a speech-language pathologist in spite of her interest in learning more:

It's definitely not an area where I devote any specific time, in terms of my continuing education. Even though it's an area of great interest to me. The demands of what I have to do for specific training and education and reading are too much in other areas, so it gets neglected. (Participant A, lines 769-775)

### **3.4.2 “My tell-tale sign”: Role of relationships in cultural safety**

*“I feel like I know if I have good rapport, and I think I can feel that, if the person is engaged and wanting to participate and be an active participant in their goal setting and all of that. I feel that that's my tell-tale sign.”*

—Participant C (lines 468-473)

While several participants talked about building relationships as part of service delivery (as described in Section 3.2.1), they also recognized its importance in the context of providing culturally safe care. All quotes in this section emerged in the participants' discussion of culturally safe care. For example, one participant expressed that building rapport and establishing trust with her Aboriginal patients allows them to know that she is “listening to their perspective” (Participant E, line 474). Another participant expressed that she asks more questions to learn more about the patient “instead of telling things right away” (Participant C, line 384), thus making the situation “less medical” (Participant C, line 387) and more of a “casual conversation” (Participant C, line 388). In doing so, this participant suggested: “So that it doesn't look like, oh, I'm up here, I'm the professional who's going to tell you what to do. I'm kind of trying to make this really a relationship of what do you want out of this and how can we make this work together” (Participant C, line 390-392). One participant also acknowledged the role of building

relationships by considering the nature of brain injury impairments, as expressed in the following comment:

Especially around traumatic brain injuries, because it takes a long time for everything to register, I think it helps to really build good rapport and kind of keep going back so they feel more comfortable with you. And then they feel comfortable asking you different questions or getting new information that they probably wouldn't have if you just went in once. (Participant D, lines 771-775)

Another participant believes that if she is able to establish good rapport in which the patient becomes “an active participant in their goal setting” (Participant C, line 471), then that is a “tell-tale sign” (Participant C, line 473) that she is providing culturally safe care. This suggests that this participant looks for signs from the patient to judge her provision of culturally safe care. The same participant recalled another experience where she “jumped in” (Participant C, line 657) with an Aboriginal client (who did not have a brain injury) as she had to conduct an assessment with the client on very short notice and consequently was not able to take the time to build rapport first: “He was kind of put off a little bit, but then still agreed to continue with me. And I think one issue might have been that lack of rapport” (Participant C, lines 678-679).

One participant recognized that patients may also have different coping strategies and uses humour to build rapport with her patient. In particular, if she notices that her patients are joking with her, possibly because they are anxious or nervous, she makes an effort to create a comfortable atmosphere, as illustrated in the following comment:

And yeah, I'll joke back. And then, you set a nice easy mood, like, hey I'm not coming in and telling you what to do, and lording over you. And I'm here to help you out and share a laugh, if that's even better, building rapport. (Participant B, line 629-641)

Some participants have also had experience working with family members, expressing the benefits of connecting with the patient's family members or relatives to learn more about their culture and background in order to provide culturally safe care. Often, the participants would rely on families as collateral sources of information, as one participant remarked: "So trying to engage [the family] and sometimes it ends up being more of a just a discussion with the family instead of going in and doing a full blown assessment" (Participant D, lines 872-874).

One participant particularly highlighted the importance of building rapport with family members to create a trusting, calm, and safe environment. She shared an experience of building rapport with a client's sister: "I was able to explain a little bit more of what we had been doing together and the progress [her brother] had made and [the sister] looked like she was a little bit calmer" (Participant C, lines 753-754).

### **3.5 Conclusion**

In summary, it is evident from the interviews that there is a wide range and diversity in participants' experiences in working with Aboriginal adults with ABI. Participants' overall perspectives shaped into four broad topic areas. The first topic provided a descriptive overview of the context of service delivery in providing services to adults within the participants' health care settings. The second topic highlighted two themes that emerged from participants' experiences in providing services to Aboriginal and non-Aboriginal adults with ABI and their families. The third topic explored three themes that participants considered to be specifically related to working with Aboriginal adults with ABI. Finally, the fourth topic looked into two themes that illustrated participants' perspectives regarding cultural safety.

## **Chapter 4: Discussion**

This research study was designed to explore speech-language pathologists' perspectives about approaches to working with Aboriginal adults with acquired communication disorders as a result of brain injury. A review of literature showed that researchers from Australia and New Zealand have explored this topic by focusing on experiences of speech-language pathologists and of Aboriginal peoples with ABI and their families. Canadian studies from northwestern Ontario have explored rehabilitation challenges faced by Aboriginal clients during their recovery from ABI through perspectives of the clients and health care professionals in general. Overall, there is little research specific to Aboriginal adults with ABI and virtually no research in regards to working with Aboriginal adults with ABI in a speech-language pathology context in Canada.

In this chapter, this study's findings are broadly discussed in the context of the current literature from Australia, New Zealand, and Canada in approaches to working with Aboriginal adults with ABI. The first section focuses on drawing similarities between this study's findings and the current literature from Australia, New Zealand, and Canada. The second section addresses particular themes that emerged and topics that were formed from the data, but were not studied in-depth by the current literature from Australia, New Zealand, and Canada. Because the themes from this current study are based on perspectives and experiences of speech-language pathologists, they bring attention to specific issues in working with Aboriginal adults with ABI in British Columbia. Finally, the third section discusses the implications for speech-language pathology in approaches to working with Aboriginal adults with ABI, limitations of this study, and directions for further research.

## **4.1 Similar Issues Found in the Context of Approaches to Working with Aboriginal Adults with Acquired Brain Injury**

Despite differences in geographical regions and Aboriginal communities involved with each study, there are several notable similarities in the results between this study and the current research from Australia, New Zealand, and Canada in approaches to working with Aboriginal adults with ABI. These similarities include service delivery issues, participants' identification of their own skills in working with Aboriginal people, and the importance of family and community support for Aboriginal patients.

### **4.1.1 Service delivery for Aboriginal adults with acquired brain injury**

Participants from this study and Keightley et al.'s (2009, 2011a) studies highlighted similar barriers when working with Aboriginal patients from remote communities. Keightley et al.'s (2009, 2011a) participants reported poor protocols for rehabilitation and discharge procedures, resulting in inadequate delivery of post-discharge services to patients with ABI upon their return home. This type of barrier was also briefly mentioned by some participants from this study, in which patients from remote communities experienced delayed discharges for reasons such as the lack of community services that are available. In addition, participants from this study commented on the lack of follow-up services with their patients after discharge.

Another finding that is consistent with both studies by Hersh et al. (2014a) and Keightley et al. (2009) is the inappropriate service delivery model that is in place for many Aboriginal peoples living in remote areas, because the health care system currently favours the movement of patients from remote communities to resource-heavy urban areas. Several participants from this study commented on the limited or lack of resources available in remote communities, thus resulting in Aboriginal patients needing to relocate to receive adequate services. Consequently,



Aboriginal patients may face large social and cultural adjustments, further compounded by their ABI, in trying to adapt to a new and unfamiliar environment. With relocation, many patients may also not have the same family or community support that they would have in their home community. Two participants highlighted the potential of videoconferencing services, such as Telehealth. Not only does Telehealth decrease the distance between the patient and their clinician, it also allows patients to remain in their home community and stay close to their support system. SAC released a position paper on the use of telepractice, i.e., the use of technology to deliver audiology and speech-language pathology services at a distance (Speech-Language & Audiology Canada, 2006). Telepractice helps to increase access to services and reduce the need for patients to relocate or travel long distances for services. Moreover, telepractice can maximize the use of available patient supports through training caregivers or educating service providers in the patient's home community.

#### **4.1.2 Speech-language pathologists' identification of level of skills in working the Aboriginal peoples**

The survey findings from Hersh et al.'s (2014b) survey revealed that only a small group of speech-language pathologists in Australia see large numbers of Aboriginal clients, suggesting that there are few opportunities for speech-language pathologists to gain confidence and develop appropriate services to meet the needs of Aboriginal peoples. This was also reflected through this current study's participants' description of their respective caseloads, in which all of the participants mentioned that their caseload generally includes only a relatively small number of Aboriginal patients. These findings may shed light into the reasoning behind the participants' reflections on their own professional skills, because as Hersh et al. (2014b) state, a smaller

caseload may translate to relatively fewer opportunities to develop experience and skills in working with Aboriginal patients with ABI.

Hersh et al.'s (2014b) survey, Hersh et al.'s (2014a) narrative analysis, and Keightley et al.'s (2011a) study highlighted participants' reflections on their own professional skills in working with Aboriginal people. Overall, the speech-language pathologists from these studies reported a lack of knowledge and education regarding Aboriginal culture. Similar reflections were also captured in this study: some participants made comments about their discomfort in addressing complicated topics or their self-awareness of their limited skillset in working with Aboriginal peoples. Along with these reflections, some participants also expressed a need for and interest in continuing education in cultural safety in the context of working with Aboriginal peoples. However, the competing demands for continuing education may be challenging for some speech-language pathologists.

Additionally, the presence of accompanying additional health conditions was another challenge that participants from this study and Keightley et al.'s (2009) study encountered. Keightley et al. (2009) identified such conditions, which can include drug and alcohol addictions and mental disorders that can reduce potential for a good recovery. Substance use and related harm, which are sometimes the result of early trauma, such as residential school experiences, have consistently been identified as top priority health concerns by First Nations (Thunderbird Partnership Foundation, 2011). The participants commented on the complexity and their own discomfort in addressing these underlying issues. Participants' reflections suggest that there is a need for resources and professional training to understand the impacts of colonization to assist health care professionals in addressing these underlying issues.

### **4.1.3 Family and community support**

The family system is an important component of Aboriginal culture and the concept of family is seen as much broader than in much of western society (Castellano, 2002; Dragonfly Consulting Services Canada, n.d.; First Nations Health Authority, n.d.; Thunderbird Partnership Foundation, 2011; Tousignant & Sioui, 2009). Immediate and extended Aboriginal families are often interchangeable (First Nations Health Authority, n.d.) and family is almost coextensive to community (Tousignant & Sioui, 2009). Thus, Aboriginal peoples have strong family values, where community is prioritized over individualism (Dragonfly Consulting Services Canada, n.d.).

Aboriginal families take a variety of forms and Castellano (2002) states that, despite the movement of Aboriginal individuals from rural communities to urban areas to pursue education and employment opportunities, “the notion of caring, effective, extended family, co-extensive with community, continues to be a powerful ideal etched deep in the psych of Aboriginal people” (p. 16). The concepts of family and community also have strong ties with Aboriginal views of holistic health and well-being. For many First Nations communities, holistic health promotes a balance between mental, physical, emotional, and spiritual aspects of life that includes a secure sense of self, personal dignity, cultural identity, and feelings of being connected (Thunderbird Partnership Foundation, 2011). Accordingly, First Nations cultural identity is shaped by family (Thunderbird Partnership Foundation, 2011; Tousignant & Sioui, 2009), along with community, traditional land, and clan systems (Thunderbird Partnership Foundation, 2011).

It is therefore not surprising that the importance of family and community support has resonated throughout the studies from Australia, New Zealand, and Canada, as well as with the participants in this study. The personal stories shared by three Aboriginal clients living with ABI

from Armstrong et al.'s (2010) study highlighted the importance of family support with examples of their family members assisting in their daily activities. Similarly, McLellan et al.'s (2014) study discussed the impacts of change in whānau and community roles and whānau relationships after aphasia.

Participants in this study had a tendency to describe family and community support within the context of service delivery, while also highlighting its positive impact on the patient's health and well-being. Family and community is particularly meaningful for patients who come from remote communities and are transferred or relocated to urban areas, where they may encounter social and emotional challenges when they are no longer close to their support. Accordingly, clinicians may need to redefine how they engage with multiple family members and communities in the context of service delivery and providing meaningful care for Aboriginal peoples. For example, Keightley et al.'s (2009, 2011a) studies suggested creating specialized services by increasing the role of First Nations communities with appropriate training to provide adequate community support. Specialized services can also help to relieve pressure from outside service providers who are not able to meet the community's needs.

#### **4.2 Issues in Working with Aboriginal Adults with Acquired Brain Injury in British Columbia**

This section outlines particular themes and topics that were salient in this study and were not studied in-depth by the pre-existing literature from Australia, New Zealand, and Canada in approaches to working with Aboriginal adults with ABI. The themes and topics illustrated by speech-language pathologists' experiences may provide deeper insight into shaping culturally safe speech-language pathology practice for Aboriginal peoples in British Columbia. This section includes the following: (1) a discussion on the importance of building relationships with

patients and family members in the context of service delivery and providing culturally safe care; (2) a further look into the theme of language, culture, and identity that captured participants' experiences in working with Aboriginal patients from an endangered language community and with possible First Nations English dialects; (3) a discussion of the theme of participants' growing awareness of Canada's colonial histories; and (4) a discussion of the concept of cultural safety as an important component in working with Aboriginal peoples in health care.

#### **4.2.1 Building relationships**

As an important component of speech-language pathology practice, many participants from this study heavily emphasized the importance of building relationships with patients and their family members in the context of service delivery. In particular, participants highlighted several aspects of building relationships, such as acknowledging its usefulness to tailor therapy to their patient's interests and recognizing potential power imbalances. In addition, some participants recognized building relationships with their Aboriginal patients as an important component of cultural safety, suggesting that building partnerships and trusting relationships may lead to a process of creating a culturally safe environment for their Aboriginal patients and family members. Due to Canada's colonial legacy and the health disparities and inequalities faced by many Aboriginal individuals and communities today, hesitation and reluctance from both Aboriginal peoples and health care professionals may present significant barriers to building genuine relationships (Zeidler, 2011). Further, Zeidler (2011) states that as Aboriginal peoples and communities are unique, there is with no "set formula" (p. 138), resulting in uncertainty in approaches to establishing partnerships with Aboriginal peoples.

The only earlier study of approaches to working with Aboriginal adults with ABI to discuss relationships was Keightley et al. (2011b). Participants from Keightley et al. (2011b)

briefly mentioned working together as traditional healers, cultural coordinators, and mental health case managers to better understand western and traditional approaches in ABI recovery, as well as educating family members and the community to support Aboriginal adults living with ABI. However, there are other research studies available that specifically address building relationships with Aboriginal peoples (Smylie, 2000; Zeidler, 2011). These studies help guide health care professionals in working with Aboriginal peoples, while focusing on the importance of building relationships with the Aboriginal individual, their families, and community at large. Smylie's (2000) policy statement, reviewed by the Aboriginal Health Issues Committee and approved by the Executive and Council of the Society of Obstetricians and Gynecologists of Canada, provides a general overview of information and recommendations for health care professionals working with Aboriginal peoples. These recommendations include considerations of sociocultural context (i.e., recognizing the need to provide health services for Aboriginal peoples as close to home as possible); health concerns (i.e., appreciating holistic definitions of health as defined by Aboriginal peoples); cross-cultural understandings (i.e., building relationships based on mutual respect and the importance of family and community roles); and Aboriginal health resources (i.e., supporting the creation of community-directed health programmes and services).

Additionally, Zeidler's (2011) study interviewed eight community members from the Lil'wat Nation to explore their perspectives in what they feel is important and helpful for non-Aboriginal professionals to know before working with their people. Nine themes emerged from the data that described the community members' perspectives on ways health care professionals can build relationships: (1) connect with the people and the place; (2) be aware of the impact of past experiences; (3) learn about the history and traditions of the people; (4) take time and let the

community know who you are; (5) learn from colleagues to understand families; (6) know the community before providing assessment; (6) be community-centered; (7) support traditional culture and language; and (8) maintain a supportive attitude and develop a genuine understanding (Zeidler, 2011). Several of Zeidler's (2011) themes resonate with perspectives of participants from this study as well, specifically in increasing awareness of the colonial history, learning about the patient's culture, and connecting with colleagues (i.e., Aboriginal support workers). However, it is important to reiterate that the current study's findings are perspectives of speech-language pathologists specifically in hospital settings, rather than from Aboriginal peoples themselves.

Additionally, it is important to note that Zeidler (2011) has worked as a speech-language pathologist in the Lil'wat community for 14 years, thus emphasizing that building genuine relationships is a long-term commitment. Given the destructive impact of the colonial history endured by Aboriginal peoples, time is needed in order to build trust and acceptance with their health care professional. While Zeidler's (2011) themes provide valuable insight into expectations of community members, the themes are community-specific and therefore, it is challenging to translate several of these themes to an acute setting. Unfortunately in acute care, there is little time for health care professionals to build relationships with their patients. Participants from this study have highlighted the fast-paced flow of acute care, in which patients are immediately discharged once they are medically stable. As a result, participants find that they sometimes do not have enough time to build relationships and rapport. Additionally, the transfer of patients from their home communities to access centralized health services makes it difficult, if not impossible, for clinicians to get to know those home communities.

The fast-paced, acute type of service delivery may not be an appropriate and culturally safe model for Aboriginal patients, who especially have a different construct of health than the western perspective. This suggests the importance for health care professionals to develop a deeper understanding of what Aboriginal patients consider as important in acute care in order to appropriately address their needs. In acknowledging that speech-language pathology services are traditionally rooted in the biomedical model, Zeidler (2011) also emphasized the importance of expanding speech-language pathology services beyond the western focus to become more community-focused and -centered. Accordingly, adjusting the health service delivery model to become more meaningful and relevant for Aboriginal peoples may help address current gaps in Aboriginal health disparities and inequalities. For example, speech-language pathologists can connect more with their respective Aboriginal support workers and social workers, as these are two groups of health care professionals who are knowledgeable about issues related to Aboriginal peoples in health care, such as funding, and who may work more regularly with Aboriginal individuals and communities.

#### **4.2.2 Endangered languages and First Nations English dialects in British Columbia**

The quote from section 3.3.1, “it felt like a whole community was losing something,” captures the historical impact of colonialism that has negatively contributed to the loss of Aboriginal languages, traditional practices, and cultural identity. The reality of British Columbia’s status of First Nations languages was brought to one participant’s attention through working with an elder who was the last native speaker of the language. From the literature review, aspects of working with endangered languages were not captured from the Australian, New Zealand, and Canadian studies. This may be because Aboriginal languages in Australia and New Zealand are more prevalent. For example, Māori is one of the official languages in New



Zealand. Only Keightley et al.'s (2009, 2011a) studies included language-related discussions, such as the need for First Nations translation services as part of improving service delivery and providing culturally safe care.

The results from this study also revealed cultural differences in communication not highlighted in the studies from Australian, New Zealand and Ontario, Canada. These included differences in degree of eye contact, slow rate, flat prosody, and imprecise articulation, which parallel to possible First Nations English dialect features as outlined in Ball and Bernhardt (2008). Only one participant used the term "dialect"; however, this participant reported to have some background knowledge of First Nations dialect features.

Ball and Bernhardt (2008) highlighted the necessity to differentiate between cultural differences in communication and language impairment in First Nations children; however, some participants in the current study acknowledged the difficulty in differentiating cultural differences in communication from communication impairments caused by brain injury. This difficulty suggests the importance of including adults in future research of First Nations dialects in British Columbia to help distinguish dialect differences from language impairments. Ball and Bernhardt (2008) state that accommodations made in a linguistically diverse society are generally "in the direction of the mainstream standard" (p. 585) and consequently act as a process of assimilation, promoting monoculturalism. Thus, it is crucial for clinicians to have the knowledge and resources to maintain cultural diversity while meeting the client's goals. Further research in First Nations English dialects will help speech-language pathologists to develop culturally relevant assessment and intervention practices that are not only relevant to Aboriginal children with language impairments, but also to Aboriginal adults with acquired communication disorders.

### **4.2.3 Growing awareness of colonial history in Canada**

Increasing knowledge of Canada's colonial history is critical for health professionals working with Aboriginal peoples, in order to provide a basis for understanding the complex socio-political realities that many Aboriginal individuals and communities have experienced and continue to experience today. Without this knowledge, health professionals, including speech-language pathologists, can fail to recognize the devastating and traumatic historical impacts of colonization and therefore cannot move forward in creating partnerships to ultimately address the health needs of Aboriginal peoples. The current study is the first to investigate Canadian speech-language pathologists' experiences in working with Aboriginal adults with acquired brain injury. The study highlighted participants' experiences in working with Aboriginal patients who were directly and indirectly affected by colonialism and have openly shared their stories with their respective clinicians: patients who are survivors of residential school or with underlying conditions that may be influenced by colonial oppression, such as alcohol, drug, mental health, and abuse related issues. While the participants tended to characterize their experiences as difficult or challenging, their stories also illustrated their patients' resilience and ability to cope.

Current literature from Australia, New Zealand and Ontario, Canada did not focus extensively on their respective colonial histories. Instead, the studies focused on present issues, such as barriers and facilitators that health care professionals and Aboriginal peoples encounter in the health care system. While not comprehensive, the current study starts to place Canada's colonial history in perspective from a health care setting. The themes that have emerged from the data particularly highlight British Columbia's colonial history, in which through working with Aboriginal individuals, participants gained a sense of the loss of language, culture, and identity, as well as social, emotional, and political impacts of colonialism. In order to move forward, it is

critical for health care professionals to become culturally competent through further education and recognition of Canada's history of colonization and assimilation that still affects the lives of many Canadian Aboriginal peoples today, as discussed in the next section.

#### **4.2.4 Cultural competency and cultural safety**

According to NAHO (2008), there are four approaches to supporting cultural safety education: (1) recognizing historical contexts; (2) recognizing diversity of populations; (3) understanding power relations between health care professionals and their patients; and (4) raising organizational awareness. Cultural safety is the outcome as defined by the Aboriginal patients who are the recipients of care and cultural competency refers to the skills of the health care professional (Health Council of Canada, 2012; National Aboriginal Health Organization, 2006). The terms are not interchangeable; as Ball (2007) states, cultural competency can be seen as the independent variable (i.e., the input) and cultural safety as the dependent variable (i.e., the output). Thus, a patient who feels culturally safe is dependent on whether the health care professional is culturally competent. Ball (2007) defines cultural un-safety as "a subjective sense that one's cherished values, goals, language, identity, and ways of life are denigrated or threatened in an encounter, or that one is being asked to venture into a foreign culture without knowing how to function in it and without positive accompaniment" (p. 11). Thus, cultural un-safety can manifest in patients' denial of impairment, low utilization and compliance of services, reticence in interactions with their service providers, anger, and low self worth (Ball, 2007).

Only a few studies from the literature review touched upon the concept of cultural safety. The participants from Keightley et al.'s (2009) study emphasized the need for more culturally sensitive training, translation services, and culturally appropriate assessment measures. According to Keightley et al. (2009), culturally sensitive training includes three orientations:

cultural sensitivity, Aboriginal-focused components of the health care system, and integration of traditional healing programs within practices. Hersh et al. (2014a) also discussed cultural safety within the theme of awareness of cultural context, which may include learning from others and adapting services for the client. Although several of the participants in this study were struck by the question of cultural safety and explicitly stated not knowing how to answer the question, some participants were able to describe situations and examples of what could be described possibly as culturally safe care (given the caveat that only the patient can say whether the care was culturally safe).

Throughout the interviews, most of the participants shared a range of stories that illustrated both positive and problematic experiences, with one participant explicitly choosing to counterbalance her positive story with a negative one. As the results show, there is great diversity in participants' experiences in working with Aboriginal adults with ABI, highlighting various barriers and facilitators in providing care for this population. As such, participants recognize the challenging realities that some Aboriginal patients may face while navigating through the health care system. This may reflect participants' degrees of cultural awareness through their acknowledgement of the diversity across Aboriginal peoples and sensitivity in moving away from stereotypes.

The PHSA ICC Online Training Program (n.d.) was created in response to the growing awareness and need for specific training for non-Aboriginal health care professionals working with Aboriginal peoples (see Appendix B). One of the goals of the ICC Online Training Program is to raise awareness surrounding the importance of building positive working relationships between the health care professional and Aboriginal patient to promote cultural safety, thus minimizing power imbalances in health care encounters. With this in mind and given the

diversity in the backgrounds of Aboriginal peoples, it is also important to consider that there is no given “formula” that can apply to all situations. However, the ICC Online Training Program helps to provide a background in Aboriginal knowledge, raise awareness, and suggest culturally safe skills that enable health care professionals to work more respectfully and effectively with Aboriginal peoples.

In addition to the PHSA ICC Online Training Program (n.d.), there are other resources available to guide health care professionals in increasing their cultural competency skills. The culturally competent communication (CCC) model, which was also used in the PHSA ICC Online Training Program, integrates frameworks of cultural competency with models of effective patient-centered communication (Teal & Street, 2009). The CCC model describes specific skills for health care professionals to enhance effective communication across cross-cultural encounters in health care: (1) non-verbal skill; (2) verbal skill; (3) recognition of potential cultural differences; (4) incorporation of and adaptation to cultural knowledge; and (5) negotiation and collaboration. These skills involve three domains in establishing a relationship, gathering information, and managing the problem. Participants from this study provided some broad examples highlighted in Teal and Street’s (2009) CCC model. For example, some participants demonstrated use of verbal skills in learning about the patient’s culture and background, while also recognizing potential cultural differences by managing the encounter through reflecting the patient’s perspective and requesting for feedback. Some participants also reported incorporating cultural knowledge by tailoring treatment that reflect the patient’s preference and needs.

Speech-language pathologists may find it beneficial to use the CCC model to guide their clinical practice in working with Aboriginal peoples. Other skills that might be learned include:

skills related to negotiation and collaboration, as described in the CCC model, that may help in situations similar to the one participant who reported challenges in obtaining information from her patient. The CCC model also provides examples of non-verbal behaviour skills, such as allowing silence and mirroring patient's facial expression to indicate empathy, which were not mentioned by any of the participants. Overall, cultural competency and cultural safety is critical in health care and continuing education to increase skills in cultural competency should be prioritized amongst health care professionals.

### **4.3 Implications for Speech-Language Pathology, Study Limitations, and Directions for Future Research**

This research study conducted semi-structured interviews with only speech-language pathologists, who were regarded as the key informants, to answer the research questions. It is important to note that while the participants come from different backgrounds and cultures and work in different hospital settings, their perspectives in approaches to working with Aboriginal adults do not in any way represent all speech-language pathologists in British Columbia. A provincial survey, similar to the one conducted by Hersh et al. (2014b), may be the next step in providing a more comprehensive picture of the current barriers and facilitators in approaches in working with Aboriginal adults with ABI in British Columbia, thus further informing culturally safe speech-language pathology practice.

A critical point in considering the implications of this study is that there were no Aboriginal participants. Because this was an exploratory study, only a group of speech-language pathologists were included as the first step in opening a dialogue to investigate what issues may be present. For future research in this area, it would be crucial to include Aboriginal patients, families, and support workers in order to provide a broader and richer understanding of

Aboriginal patients' ABI recovery in a speech-language pathology context and to explore their cultural understandings of acquired communication disorders and perspectives of acute care. Aboriginal people are the ones who determine whether the care that they receive is culturally safe and thus their perspectives are vital to advancement in health care practice. Further understanding of what Aboriginal peoples consider as important and culturally safe can ultimately help guide speech-language pathologists in providing culturally safe care in ABI recovery to Aboriginal patients. Research by Armstrong et al. (2012), Keightley et al. (2011b), and Zeidler (2011) exemplify the significance of including Aboriginal participants. Such future studies will offer a deeper understanding of Aboriginal expectations and help health care professionals provide culturally relevant and meaningful services to better support ABI recovery.

Finally, the current study, along with pre-existing studies from Australia, New Zealand, and Canada, shows the need for broader research to develop an understanding of the relevant issues that Aboriginal adults with ABI encounter in a speech-language pathology context. This may include areas such as long-term recovery processes, service and discharge policies, and expectations of Aboriginal peoples. The results from this study also show that further research surrounding First Nations English dialects is urgently needed. Research in First Nations English dialects should also include Aboriginal adults with and without acquired communication disorders in the same community in order to guide speech-language pathologists in making accurate diagnoses of speech and language impairment versus cultural differences in communication. Moreover, further research in this area will allow speech-language pathologists to develop culturally relevant assessment and intervention practices for Aboriginal peoples.

#### 4.4 Conclusions

A wide range of perspectives was captured across the interviews and highlighted the diversity in speech-language pathologists' experiences in working with Aboriginal adults with ABI in British Columbia. From the interview data, four topics were identified: (1) a descriptive overview of service delivery for adults in British Columbia revealing various barriers and facilitators; (2) within the context of service delivery, participants' emphasis on working with patients and families; (3) participants' acknowledgment of issues that they considered to be specific to Aboriginal peoples; and (4) participants' current understandings of cultural safety. Themes that emerged from the second, third, and fourth topic reflect the participants' personal statements around: building relationships with patients; family and community support; Aboriginal languages, culture, and identity; awareness of the impacts of colonization in health care; move toward holistic practice; participants' feelings of uncertainty with respect to the concept of cultural safety; and the role of building relationships in the provision of culturally safe care. Given the Canadian colonial and assimilative history that still affects the lives of many Canadian Aboriginal peoples today, it is critical for health care professionals to become culturally competent through continuing education. This is because, ultimately, it is Aboriginal patients themselves who determine whether the care they receive is culturally safe, but it is the cultural competence of health professionals, working together with Aboriginal people, that can create a culturally safe environment for that care.



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## Appendices

### Appendix A: Interview Guide

(1) Tell me about your background working with Aboriginal clients with ABI.

*Probe Questions:*

- How long have you worked with the Aboriginal population?
- How often do you see and work with Aboriginal clients in your caseload?
- Tell me about the mix of Aboriginal clients you would see in your caseload. For example, what community are they from and why were they referred to you?

(2) Can you tell me about some of your experiences working with Aboriginal clients with ABI?

For instance, can you think of any stories that particularly stood out for you that may have highlighted your experience working with a client from an Aboriginal background?

*Probe Question:*

- What kinds of issues have come up in your work with the Aboriginal population? For example, issues that may surround referral, assessment, treatment, discharge, working with Aboriginal support workers, team meetings, and community services.

(3) What does providing culturally safe and appropriate care mean to you?

*Follow-up questions:*

- What have you done to prepare or educate yourself to provide culturally safe care?
- Can you talk about how you implement culturally safe care in your clinical practice?

*Probe Questions:*

- How do you know you are providing culturally safe care? Do you check with your clients?
- What kinds of changes have you made to provide culturally safe care? For example, are there additional assessments you use or changes you make during therapy sessions?

## Appendix B: Resources

### Relevant Background Information:

- First Peoples' Language Map of British Columbia

*Retrieved from:* <http://maps.fphlcc.ca/>

*Description:* Indexes of all First Nations languages and communities in British Columbia.

- First Nations Perspective on Wellness

*Author:* First Nations Health Authority

*Retrieved from:* <http://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/first-nations-perspective-on-wellness>

*Description:* The visual depiction of First Nations Perspective on Wellness is a tool to help create a shared understanding of a holistic view of wellness.

### Cultural Safety:

- Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators

*Author:* National Aboriginal Health Organization

*Retrieved from:*

<http://www.naho.ca/documents/naho/publications/culturalCompetency.pdf>

*Description:* A general guide that provides background information on cultural competency and cultural safety and why it is critical for health care professionals to become culturally competent. General guidelines for providing culturally safe care are also included.

- Fact Sheet: Cultural Safety

*Author:* National Aboriginal Health Organization

*Retrieved from:* <http://www.naho.ca/documents/naho/english/Culturalsafetyfactsheet.pdf>

*Description:* A quick summary on cultural safety.

#### Professional Skills:

- Indigenous Cultural Competency (ICC) Online Training Program

*Developed by:* Provincial Health Services Authority in BC

*Retrieved from:* <http://www.culturalcompetency.ca/>

*Description:* The ICC training is designed to increase knowledge, enhance self-awareness, and strengthen skills of health care professionals who work with Aboriginal peoples. Anyone who is directly employed by a provincial health authority or the Ministry of Health is qualified to take the training free of charge. The Core ICC Health training takes approximately eight hours to complete over an eight-week period. Certification of completion is awarded at the end of training.

- A Resource Kit: To Assist Speech-Language Pathologists and Audiologists in Providing Informed Services to First Nations, Inuit, and Métis People

*Author:* Elizabeth Kay-Raining Bird

*Retrieved from:*

[http://cjslpa.ca/files/2014\\_CJSLPA\\_Vol\\_38/No\\_02/CJSLPA\\_Summer\\_2014\\_Vol\\_38\\_No\\_2\\_Paper\\_8\\_Kay-Raining-Bird.pdf](http://cjslpa.ca/files/2014_CJSLPA_Vol_38/No_02/CJSLPA_Summer_2014_Vol_38_No_2_Paper_8_Kay-Raining-Bird.pdf)

*Description:* This resource kit was compiled to assist speech-language pathologists and audiologists in providing culturally and linguistically appropriate services to Aboriginal peoples. The resource kit includes various research-based clinical resources developed by SAC; government, provincial, and territorial websites; Aboriginal organization websites;

resources related to Canada's colonial history and Aboriginal dialects and languages; and information on cultural safety.

- Culturally Competent Communication (CCC) Model

*Reference:* Teal, C. R. & Street, R. L. (2009). Critical elements of culturally competent communication in the medical encounter: A review and model. *Social Science & Medicine*, 69, 533–543.

*Description:* The CCC model integrates frameworks of cultural competency with models of effective patient-centered communication. The authors provide descriptions of specific skills and behaviours health care professionals can use to enhance effective communication across cross-cultural encounters in health care.

Aboriginal Dedicated Services:

- Aboriginal Patient Navigators (APN)

*Health Authority:* Vancouver Coastal Health and Interior Health

*Retrieved from:* For Vancouver Coastal Health: <http://aboriginalhealth.vch.ca/health-services/apn/aboriginal-patient-navigators>; for Interior Health: <https://www.interiorhealth.ca/YourHealth/AboriginalHealth/Pages/APN.aspx>

*Description:* The goal of the APN program is to help Aboriginal peoples access health care and community services. Contact information for Vancouver Coastal Health's and Interior Health's APNs is available on their respective websites.

- Aboriginal Health Program

*Health Authority:* Vancouver Island Health Authority

*Retrieved from:* [http://www.viha.ca/aboriginal\\_health/](http://www.viha.ca/aboriginal_health/)

*Description:* The Aboriginal Health Program consists of various team members, such as

Aboriginal Liaison Nurses and Community Dietitians, to maintain and improve the health of Aboriginal peoples living on the Vancouver Island and nearby areas. Contact information for the North Island, Central Island, and South Island teams is listed on the website.

- Aboriginal Patient Liaison (APL) Program

*Health Authority:* Northern Health

*Retrieved from:*

<https://northernhealth.ca/YourHealth/AboriginalHealth/WhatWeDo/AboriginalPatientLiaisonProgram.aspx>

*Description:* As part of the health care team, the goal of the APL program is to ensure a holistic health approach for Aboriginal patients and families. There are nine APLs in the north. Contact information and service locations for all APLs are listed on the website.

- Aboriginal Health Team

*Health Authority:* Fraser Health

*Retrieved from:* <http://www.fraserhealth.ca/your-health/aboriginal/about-aboriginal-health/aboriginal-health-team>

*Description:* The Aboriginal Health Team acts as a liaison to assist Aboriginal peoples with mainstream health services. Contact information and service locations are listed on the website.