

# **Biigiiweyan (“Coming Home”): Social Work and Health Care with Indigenous Peoples from Competency to Safety**

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## **Abstract**

Cultural competency reproduces simplistic assumptions about Indigenous Peoples that are reminiscent of imperialism (Pon, 2009), directing service providers to become more sensitive to so called “norms”, “practices” and “behaviours” (Baskin, 2016). This freezes culture, ignores diverse languages and histories as well as the places and contexts that animate the realities of Indigenous Peoples. The result is limited understanding of the systemic and structural challenges and the skills needed by helpers to navigate and advocate against such barriers. Going beyond cultural competency to safety includes an awareness of ways in which “historical, economical, and social contexts” influence our position (Gerlach, 2012, p. 152) in terms of power and privilege. It recognizes current expressions of colonization and prioritizes Indigenous healing and wellness practices within helping relationships. Based on two years of research with Elders, Knowledge Keepers, community members, helping professionals, educators and students, Biigiiweyan is a cultural safety training model that offers a roadmap for educational and training programs to make the jump from

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competency to safety. Founded in Indigenous ways of knowing and relating, Biigiiweyan utilizes interprofessional training and live actor simulation and offers a rubric of cultural safety learning outcomes defined by Indigenous Peoples.

## **Introduction**

Cultural competency has often been associated with assisting mostly White service providers in offering social services to Indigenous Peoples. However, in recent years, this model has been critiqued by Indigenous and racialised social work educators and other healthcare professionals as simplistic, paternalistic and racist. Another model, known as cultural safety, which was coined by an Indigenous healthcare provider, holds more promise in service provision as it places the focus on the current impacts of colonisation on Indigenous Peoples, highlights Indigenous forms of helping and emphasises self-reflexivity on the part of those offering services. These elements of cultural safety became clear through a research project in Ontario, Canada with Indigenous Peoples on a cancer care journey which resulted in the creation of simulations for students and service providers working with individuals, families and communities.

For the purposes of this article, the term “Indigenous” is an inclusive term to describe individuals and collectives who consider themselves as being related to and/or having historical continuity with ‘First Peoples’, whose civilisations in what is now known as Canada predate those of subsequent invading or colonising populations.

## **Mission Impossible: Critique of Cultural Competency from Indigenous Perspectives**

In attempts to address ‘issues of diversity’, many educational programs and helping professions have endeavoured to create service providers who are culturally competent, sensitive and aware in order to work with people who are not like them. Over the past several decades, cultural competency models have directed helpers to become more aware of, and sensitive to, the so called norms, practices and behaviours of ‘cultural’ groups, often with an emphasis on Indigenous Peoples (Acton, Saltera, Lenoya, & Stevenson, 2017; Churchill, Parent-Bergeron, Smylie, Ward, Fridkin, Smylie & Firestone, 2017; Dzidic, Breen, & Bishop, 2013; Hollinsworth, 2013; Rego, 2014). Developing heightened sensitivity to these norms, practices and behaviours is seen to be beneficial to the relationship between the service provider and the service user as services may then be offered within the framework of a group’s culture.

Such models are taken up not only by dominate services, but also by some Indigenous

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organisations and agencies, such as the Truth and Reconciliation Commission of Canada (TRCC) (2015), the Ontario Federation of Indigenous Friendship Centres (OFIFC) (n.d.) and numerous Indigenous service providers (Yaphe, Richer, & Martin, 2019). For example, OFIFC (n.d.) offers training that aims to:

- Provide an Aboriginal Cultural Competency Framework for addressing different levels of cultural competence;
- Provide participants with a basic understanding of how to interact with Aboriginal communities; and
- Share culture-based strategic planning methods for improved organisational cultural competence.

Not unlike anthropology, cultural competency creates a set of attributes which are assigned to ‘the other’ and then managed as collective cultural identities. This emphasis on management and service provision is assumed to provide mostly White social services and healthcare providers with an increased ability to communicate with Indigenous populations. Cultural competency merely acknowledges the differences of Indigenous Peoples as compared to dominant society and sees diversity itself as the problem. For example, medical students in one research project attributed their “awkward, difficult clinical situations” with Indigenous patients to the latter’s “diversity issues”, thereby framing diversity as the cause of their difficulties rather than their own inadequacy in addressing it (Walters, Simoni, Evans-Campbell, Udell, Johnson-Jennings, Pearson, MacDonald, & Duran, 2016, pp. 387–388).

Various Indigenous and non-Indigenous social work scholars have critiqued cultural competency models, taking the position that it reproduces simplistic assumptions about Indigenous populations that are suggestive of the imperialism, racism and paternalism of an earlier social work era (Baskin, 2016; Dumbrill, & Yee, 2018; Hart & Rowe, 2016; Pon, 2009; Prue, 2016; Snowshoe, & Starblanket, 2016) that is continued and maintained through structural violence which the helping professions, including social work, often perpetuate. For example, there are hundreds of Indigenous cultures globally, numerous languages spoken, and multiple traditions which are further complicated by class, gender, age, sexual orientation and spiritual beliefs. Without an understanding of these complexities, ideas about cultures can then become simplified and practitioners can fall into the trap of seeing culture as the only variable in the lives of individuals, families or communities. Furthermore, an emphasis on attempting to learn about a culture creates generalisations that limit rather than enhance communication and effective services for Indigenous Peoples.

Of significance, cultural competency models do not consider the context of how, where and why Indigenous Peoples meet service providers. The latter must be

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cautious in theorising 'Indigenous ways of knowing', remembering that they cannot be universalised, but rather localised articulations are needed, such as what Indigenous Nation someone belongs to, the geographical area they come from, and whether they live in rural Indigenous communities, urban areas or small towns. Even if a practitioner somehow became competent in one Indigenous Nation's culture by spending years working with one of its communities, this cannot make them knowledgeable in all Indigenous cultures as the diversity amongst various Nations is vast.

A cultural competency model can also reduce the understanding of the difficulties that Indigenous individuals face, when accessing social services, to cultural differences, rather than attending to the social, economic and political realities that support systemic inequalities. Thus, when structural power inequities are conceptually removed from one's understanding, oppression may easily be attributed to individual prejudice and/or 'cultural barriers'. The cultural competency model is limited because it doesn't consider power differences and the ways power is maintained through a social hierarchy that marginalises Indigenous Peoples.

There is also an assumption within the cultural competency model that the practitioner is 'culture free'. The assumption that she/he/they is White, and therefore has no culture, is prevalent. Only the 'other' has culture. However, the reality is that everyone has a culture and is influenced by culture. The ways social workers regard service users, understand challenges and work on possible solutions to these challenges are shaped by cultural understandings. Further, the culture of the helping professions is largely shaped by the understandings of the dominant group. Even if the social worker is a member of an Indigenous group, she/he/they will inevitably practice social work, at least in some measure, using the cultural understandings of the dominant group as they have been educated in dominant worldviews and perspectives.

In addition, several articles, based on research in Australia, Canada, New Zealand and the United States, reported that cultural awareness only acknowledges difference without providing adequate teaching about application to practice (Kurtz, Janke, Vinek, Wells, Hutchinson, & Froste, 2018). For example, a report of psychology, occupational health and nursing students' immersion experience in a Native American community in the United States, found minimal evidence reporting immersion in one culture enables students to apply learned culturally sensitive knowledge when working with other cultures (Kurtz et al., 2018). Similarly, graduate social work students in Australia who attended a one-day cultural immersion, were unable to fully grasp the importance of Indigenous community engagement (Kurtz et al., 2018).

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Other research shows the difficulties of measuring student levels of cultural competence as well as the lack of empirical evidence demonstrating that such models improve Indigenous health outcomes (Carey, 2015). In addition, there is little critique built into cultural competence pedagogy, meaning that its beliefs are often unquestioned within educational programs such as social work (Carey, 2015). Nevertheless, in research with interdisciplinary service providers in Canada, when asked about training expectations, almost half of participants noted that they wanted to “learn more about the culture, values, and beliefs of Indigenous people” (Yaphe et al., 2019, p. 68).

Within social work, Pon (2009) describes “cultural competency as new racism” (p. 59), meaning that racial discrimination has moved away from exclusion based on biology, towards that based on culture. In this way, social work essentialises culture which leads to a reinforcement of cultural stereotypes and a freezing of culture that renders it static. Pon’s (2009) assertion rings true that “when cultural competency constructs knowledge of cultural “others”, it forgets the history of non-whites and troubles, even renders absurd, any notion of a pure or absolute culture” (p. 63).

Further, in a critique of cultural competence, Kirmayer (2012), highlights the need to separate the content of cultural competence (knowledge, skills and attitudes) from process (mechanisms by which competence is certified and maintained) and cautions against the procedural implications of cultural competency within organisations. Institutionalising cultural competence serves political and economic purposes of “boundary marking, domination and legitimation” (Kirmayer, 2012, p. 156). As professionals are deemed competent, they gain authority in assessing competence in others and in health spaces and programs, including regulating and controlling the delivery of services. Alternatively, Indigenous social work and healthcare practices include unique training and monitoring through mentorships, ethical considerations and close community involvement. Currently, these Indigenous ways of knowing are often missing from what students and practitioners are expected to know.

### **Only Indigenous Peoples Can Decide: Cultural Safety**

The concept of cultural safety was first introduced in 1990 by Irihapeti Ramsden, a Maori nurse in Aotearoa (New Zealand) (First Nations Health Authority, (FNHA), n.d.). Cultural safety goes beyond cultural competence to legitimatise how the power of one’s own life experience, plus that of the systems in place, can have on others (Bourassa, McElhaney, & Oleson, 2016; Koptie, 2009). It attempts to address such inherent power imbalances. Although it has its roots in nursing, the concept has expanded beyond health-care professions and is now being applied in other fields such

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as social services, particularly social work and child welfare (Compton-Osmond, 2017; Green, Bennett, & Betteridge, 2016; Hollinsworth, 2013). Of note is that cultural safety has been embraced by the Assembly of First Nations, the National Aboriginal Health Organisation, and the Aboriginal Nurses Association of Canada as being an ideal approach to working with Indigenous Peoples (Brooks-Cleator, Phillipps, & Giles, 2018; FNHA, n.d.). Key elements of cultural safety for Indigenous Peoples include: Addressing racism, oppression, marginalisation and the experiences and needs of Indigenous populations;

- Culture is related to history and society and is complex and dynamic, rather than a static set of beliefs or practices;
- Professionals' self-reflexivity on their own assumptions and positions of power within social services; and
- Only Indigenous Peoples can decide what is culturally safe for them (Baskin, 2016; FNHA, n.d; Sasakamoose, Bellegarde, Sutherland, Pete, & McKay-McNabb, 2017).

Within education, the Aboriginal Nurses Association of Canada (Brooks-Cleator et al, 2018) stresses the need for cultural safety curriculum, due to the ongoing impacts of colonisation, historical and current government policies, the residential school system, sixties scoop and intergenerational/collective trauma. Similarly, academics in Australia, the United States and New Zealand (Acton et al., 2017; Brascoupé & Waters, 2009; Carey, 2015; Kurtz, et al., 2018) outline recommendations for the training of all professionals, including community leaders, teachers, and those in, for example, health, law, and social work, who work with Indigenous communities, regarding Indigenous histories and the concept and practice of cultural safety.

Specifically to this paper, researchers have indicated that Indigenous populations face a series of common barriers to receiving cancer treatment, including unequal access to cancer screening and prevention programs, practitioners' limited knowledge of Indigenous forms of healing and wellness practices, and communication challenges in hospital settings (Canadore College, 2017). Such research indicates an urgent need for improved culturally safe care across human and health care settings to address systemic stereotyping, racism and discrimination and further encourage opportunities to access and utilise strength-based approaches to care with Indigenous Peoples (Canadore College, 2017).

## **Theoretical and Descriptive Origins of *Biigiiweyan***

In response to these urgent calls, our group, consisting of researchers, educators,

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frontline workers, Elders, and community members living in the Ontario, Canada, Nipissing region, created *Biigiweyan* (“Coming Home”), an Indigenous interprofessional, cultural safety training program. *Biigiweyan* includes an Indigenous-led Interprofessional Education Training Team, a Training Program, a Rubric for evaluating Cultural Safety, a culminating simulation featuring Simulated Participants and opportunities for reflection as the training unfolds. A primary goal of *Biigiweyan* was to involve Indigenous organisations, service users and families who had experienced cancer care, educators and research partners, and health care and social work practitioners and students; to work together to create culturally safe care training for working with Indigenous people on the cancer care journey. *Biigiweyan* advances the notion of cultural safety by prioritising Indigenous ways of knowing in both design and implementation.

With cultural safety as the intended outcome, learning within the *Biigiweyan* training program was embedded in the teachings of the Medicine Wheel as conceptualised by Dr. Cindy Peltier who illustrated the interplay between the Indigenous determinants of health and the Medicine Wheel as a form of pedagogy (see Figure 1). In this model, the Distal level concerns the historical, political, social, and economic contexts of the person’s experience. The Distal includes the broader concepts of colonialism, racism, social exclusion, self-determination and the hegemony of Western medicine (Reading & Wien, 2009; Peltier, forthcoming). For the purposes of *Biigiweyan*, understanding the patient’s experience at the Distal level might include experiences with the residential school system and connections with their own cultures, and languages. The Intermediate level involves understanding the service users’ experience with access to both health care systems (Indigenous healing and Western medicine) and the hegemony of Western medicine (Peltier, forthcoming). At the Proximal level, *Biigiweyan* participants understand the relationships that patients have with Indigenous and Western health care practitioners, as well as with their families and communities (Peltier, forthcoming). Within this model, the Centre reflects the learner’s experience in gaining these understandings through seven training sessions.

As *Biigiweyan* is an Indigenous Interprofessional Cultural Safety Training Program, learning at all levels was situated in Anishinaabe *Giikendaasowin* [Anishinaabe knowledge]. Organised by a Knowledge Gifters Council, a Steering Committee, and a Research and Project Coordination Team, *Biigiweyan* was embedded within Indigenous research methodologies, and guided by wise practices for cultural safety in an effort to help create a more culturally safe healthcare training environment, and by extension, a more equitable and just healthcare system. Organising in this way avoided the ‘tokenism’ that can sometimes permeate education environments where

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efforts towards advancing reconciliation are neither properly valued nor resourced (Stein, 2020).



Figure 1: Medicine Wheel, Indigenous Determinants of Health and Cultural Safety

## Research Methods

Prior to receiving Research Ethics Board (REB) approval, a Community Engagement Plan was approved by the Office of Indigenous Initiatives at one of the participating educational institutions. To prioritise Indigenous ways of knowing, an Indigenous researcher was hired. Using Kovach's (2010) conversational method, the Indigenous researcher worked with the Steering Committee, the Knowledge Gifters Council, and the Research and Project Coordination Team to determine core inter-professional education (IPE) and cultural safety measures as well as the exposure and immersion activities needed for participants to successfully participate in the IPE simulation.

Elders and Knowledge Keepers, Indigenous community members with lived experiences, community partners who offer services to Indigenous Peoples, and Indigenous organisations who have knowledge to share regarding Indigenous health and cancer care were invited to participate in an interview. The Indigenous researcher met with 21 participants. Prior to the start of each intervention, the researcher shared the details of the project and obtained consent. Participants were asked to reflect on their lived experiences with cancer care, with follow-up questions based around the teachings of the Medicine Wheel. The interviews were digitally recorded and transcribed verbatim. When participants preferred to not be recorded, notes were taken during the interview and the researcher reflected on and added to the notes after the interview. After each interview was transcribed, a copy of each transcription was given to each participant for review and interpretative thematic analysis was used to

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### identify patterns within the data. **Story Weaving: How Interviewing Shaped Simulation and Evaluation**

Utilising the themes emerging from the interviews, the Indigenous researcher worked with a trained simulationist to create simulations for cultural safety. The simulationist engaged in a process of self-reflection and, in concert with the Indigenous researcher, ensuring that the simulations generated were informed by themes of the key interviews and not from the perspective of a singular worldview. In general, participants discussed the need for respect, advocacy, and safe space to carry out traditional healing practices and ceremonies, barriers in healthcare and the need to educate service providers on history, past and present colonisation, and current policies. These themes formed the broad learning objectives within the simulation and a rubric that could be used to evaluate the impact of *Biigiweyan* as a training program.

The data obtained from the interviews shared the lived experiences of individuals along the cancer journey; from the intake process of first learning the diagnosis, the treatment stage, and often the death of a loved one and the grief felt by the family. It was clear that more than one scenario was required to capture all aspects of the cancer journey. The Medicine Wheel also helped guide the development of the scenarios.

The stages of the cancer care journey were identified and placed within the Medicine Wheel:

1. Intake process following diagnosis - East Direction/Physical/Vision
2. Treatment and planning of care - South Direction/Emotional/Relationship to Land
3. End of Life Care/Western Door - West Direction/Spiritual/Reflection
4. Grief and the Family - North Direction/Mental/ Movement

Once the stages of cancer care were identified, traditional healing practices, emotions, challenges and barriers were integrated into the scenarios. Training participants' areas of focus were also incorporated at this stage to ensure the scenarios reflected something they would experience in their area of practice. The scenarios had to be created so all different professions within the circle of care could participate in at least one of the four scenarios.

The community identified their needs and participated in learning activities to ensure students were better prepared for the scenarios.

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Grounding scenario and simulation design, as well as the cultural safety rubric, with the views of community members, helped avoid a simulation that would feature the implicit biases of educators. Lived experiences were integrated into the story that forms the background to the scenarios, reflecting systematic realities and barriers. Particular attention was paid to recreating the realities of the lived experience in the scenarios so that the learners would learn from reality-based, simulation scenarios with Indigenous actors (Palagnas, Epps, & Raemer, 2014; Thomas, Reedy, & Gill, 2014). Importantly, Indigenous methodologies were included in all aspects of the simulation design from scenario development, pre-briefing, implementation, and debriefing. There were some aspects of Western approaches to simulation incorporated, indicative of Two Eyed Seeing or learning from the strengths of multiple perspectives for the benefit of training participants (Bartlett, Marshall, & Marshall, 2012).

Once the scenarios were created, the project hired Indigenous actors/Simulated Participants (SP) to role play the characters in the narrative. SPs bring a level of emotional and behavioural realism to a scenario and require the learner to manage intimate interpersonal situations (Nestel, & Bearman, 2015). The learner approaches the SP just as they would a real service user. The SP is then well placed during the debriefing session to give feedback through the service users' perspective (Nestel, & Bearman, 2015). This feedback is often the most important aspect to having an SP and allows learners to hear the service user's experience from inside the encounter (Nestel, & Bearman, 2015). These facilitated debriefing sessions allow for reflection on the part of the learner and are one of the key concepts to experiential learning.

### **Piloting the Biigiweyan Training Program**

In the *Biigiweyan* pilot, thirty applicants from around the community of North Bay, Ontario, Canada, including from the North Bay and Parry Sound District Health Unit and the North Bay Police Service, as well as students and faculty from Canadore College and Nipissing University, attended the seven-week training program. A wide range of topics, resulting from interviews reflecting the perspectives of community members, were covered, including colonisation, Indigenous worldviews on healing and wellness, respect, relationships, accessing health and social services, and advocacy and transformational change at the structural level. Unique to this research project was the integration of Indigenous Elders' knowledge and methodologies, such as storytelling, to help provide culturally safe conditions. What follows is a description of the pilot itself.

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## The Centre

Training sessions began in the centre of the Medicine Wheel with an examination of the self. The work in this part of the Wheel is reminiscent of Geniusz' (2009) reference to *biskaabiiyang*, an Anishinaabe concept meaning coming back or a 'returning to ourselves'. We began our *Biigiweyan* learning journey with a personal inventory of reflections on our values, behaviours, beliefs and assumptions about Indigenous Peoples, healing, cultures, communication, self-location and relationships to each of these. The first training session involved sharing and learning about the development of the project, and each participant shared their reasons for wanting to participate and what their expectations were.

During the first and subsequent training sessions, we introduced ourselves through a talking circle. This form of Indigenous pedagogy places the 'learners' and 'teachers' in a circle, removing the hierarchy common to Western classroom settings and enabling a safe space for sharing, conversation, and curiosity. *Biigiweyan* cultivated an environment for Interprofessional Cultural Safety where facilitators could be both 'teachers' and 'learners'. The pedagogical design and ease of conversation ensured that both teachers and learners could collectively contribute to a new understanding of cultural safety and the transformation of cancer care for Indigenous Peoples.

## The East

Learning in the east direction focused on the Distal level exploration of colonisation past and present, including how colonisation is an Indigenous determinant of health. We explored the notion of structural violence that is inherent in the social services and health care systems for Indigenous Peoples. *Biigiweyan*'s balanced learning process, incorporating both Western and Indigenous pedagogies, furthers the notion of cultural safety as a pedagogical approach which brought awareness to participants of the structural and colonial forces, in order to promote reconciliation and change within the helping professions (Peltier, forthcoming).

Our third session explored Indigenous healing and wellness practices through a wholistic care lens. This session exemplified the interplay between the patients' experience at both the Intermediate and Proximal levels. The importance of wholistic care and the inclusion of family and community was especially significant in this session. One precept of Indigenous healing is that it never occur in isolation and often involves relationships with family, community, helping professionals, as well as those beings within the spiritual realm.

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## **The South**

The Intermediate level concerned access to knowledge and resources. Learning in the south direction involved a discussion of wholistic community resources available to Indigenous Peoples including the protocols, referrals and funding processes for access. Participants were required to understand that relationship building continued to involve the understanding of the interplay between the Intermediate (systems) and Proximal (family and community) levels. This access-oriented session focused on building relationships in the context of an Indigenous interprofessional team and including relationships with family, community and the land.

## **The West**

The West direction's focus on spirituality, reflection and teachings that prepare transitioning to the spiritual realm heightened the importance of Indigenous teachings. The practitioner begins to understand responsibilities in end of life or after life care and their critical importance in Indigenous contexts from the Distal to Proximal level. Moving into the western direction, we explored Indigenous ceremonies and healing concerning preparation for the transition to the spirit world.

## **The North**

Coming full circle, we moved into the northern direction where we explored our work in terms of advocacy and our own roles as members of an inter-professional team welcoming Indigenous healing. This learning came with the realisation that we must address how our roles currently sit within institutions requiring change to address the existing barriers for Indigenous Peoples.

## **The Simulation**

The scope and sequence of the *Biigiiweyan* training program ensured participants had the knowledge and skills to participate in a culminating simulation experience with live actors who were Indigenous. The seventh and final session enabled learners to participate in a practical simulation putting our learning into practice. The learning involved putting the knowledge gained throughout the training sessions into a scenario involving the cancer care journey of an Indigenous service user and her family members. At the conclusion of the final session, participants were asked to return to the Centre for a re-examination of their self-location.

## **Reflections from the Biigiiweyan Pilot**

As described above, the Biigiiweyan sessions were planned and delivered using the

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medicine wheel. The reflections of the participants illustrate this journey through the four directions, including the centre of the wheel, and self-reflection through the training experience. The openness to explore new knowledge grew with each session as many participants became more vocal in their eagerness to participate in the ceremonies, and share the retelling of their stories to family and friends. Every aspect of Biigiiweyan, including the physical setting, curriculum and rubric for assessment, promoted experiential learning for participants and was designed to animate the themes shared by Indigenous community members. The experience of sitting in circle and being gifted with local teachings, created the time and space for listening and reflecting on what participants were learning and how they could put their new knowledge into practice to offer culturally safe care. The space offered privacy for the group and promoted physical, emotional and spiritual comfort. A talking stick was used, sharing the importance of equality, active and respectful listening, and turn taking in circle.

A common theme identified throughout our research, shared by both participants and members of the Elders Advisory Council, was “the importance of social workers and health care practitioners understanding and respecting Indigenous worldviews and healing and wellness practices”. This theme fits into the eastern direction of the medicine wheel which focuses on vision and knowledge. While the learning outcomes for this theme were targeted in session three (outlined in text box 1), participants had been engaging and practicing multiple aspects of this content prior to this session. Participants experienced the circle and reflected on its importance and impact. They participated in smudging and ceremony and learned about the proper Indigenous use of medicines such as tobacco.

### Text Box 1

We will explore Indigenous healing and wellness practices through a wholistic lens. We will discuss how to bring wholistic care to patients, families and community. We will highlight the roles of Indigenous wellness agencies, Elders, Medicine People and define healing practices such as a healing circle, smudging, ceremony, medicines, sweat lodge and the benefits of these wellness practices. We will explore and discuss strategies that bridge two “health care systems” and what they provide, such as physician and healer recommendations as well as “doctoring” in the sense of Indigenous healing. We will also discuss the importance of the relationship to land, plants and animals, when developing a plan of care and end of life/after life care.

Participants shared many comments that demonstrated their understanding of the theme of Indigenous worldviews of healing and wellness. One participant shared about the “interconnectedness and the appreciation of ceremony at gatherings” and that the “foundation of life is relationships”. Another shared, when reflecting on expanding IPE teams to include Indigenous wellness resource people, “It’s about people—not the occupation or hierarchy”. Multiple participants noted how they valued their experiences of smudging and how they now better understood its importance for service users. When speaking about changes they would like to have seen in the final team simulation, one participant accurately commented on the lack of Indigenous resource people on the team, and that they “would have liked to see a traditional healer as part of the team meeting scenario to learn more of their role, how it would change the interaction, and bring both Indigenous and Western views together”. Another participant shared at the beginning of the project that they were hoping to answer the question, “How do I approach an Elder, is there a way I can look up what I need to do”? This participant responded to their own question, towards the end of the training, “Now I realise the need for relationship. I can’t just go up to someone and ask. That is something important that I am taking away from this

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training”. This emphasis on relationships is the work of the southern direction of the medicine wheel. Multiple participants described being “moved” by the teachings of the western direction which includes the doorway to the spirit world and end of life teachings. They reflected on the importance of the four-day journey and the healing aspects of ceremony. Some spoke of the need to make this part of their practice.

Several participants spoke about sharing their new knowledge with the people in their lives and how, as a result of the training, they are approaching their jobs differently, so they can make positive changes to their interactions with Indigenous individuals and families. Speaking specifically to the theme of advocacy, some learners stated that they now understand the need to include local Indigenous knowledges in advocating for policy change. Participants, who are also educators, spoke about their new understanding of the need to transform education “because the students we teach will be working in and/or with Indigenous communities at a time when people are very ill, so it is important to do this right”. Putting new knowledge into practice, or taking action, is the focus of the northern direction.

## Discussion

As evidenced in the participants’ reflections, a critically important benefit of *Biigiiweyan* was the prioritisation of Indigenous Knowledges (IK) in all aspects of its planning and delivery. Three examples where this was best illustrated include: 1) utilising a Medicine Wheel framework in the design and delivery of the project; 2) the way in which IK informed the simulation-writing process, and; 3) how Indigenous simulated participants (SPs) participated in the scenario and provided feedback to trainees within the larger debriefing process. Conceptually, these key elements are congruent with what other researchers have found to be themes representing a common understanding of cultural safety; namely, the importance of collaboration and partnerships, power sharing, addressing a broad context of the service user’s life, a safe environment typified by nonjudgement, self-reflection, and training, especially for non-Indigenous practitioners (Brooks-Cleator et al., 2018).

Furthermore, *Biigiiweyan* also helps to answer specific calls for practical guidelines to move cultural safety beyond its formulations in academia to a place of implementation within the helping professions (Brooks-Cleator et al., 2018; Kitching, Firestone, Schei, Wolfe, Bourgeois, O’Campo, Rotondi, Nisenbaum, Maddox, & Smylie, 2019; Owens, 2019). For instance, the practical focus of *Biigiiweyan* has led to the creation of new teaching materials including a series of pre-training sessions, a pre-briefing, a simulation, and a debriefing model, as well as a rubric to evaluate participants’ progress.

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Along the same lines, it should be highlighted that the experiential nature of *Biigiweyan* is in line with what Pitama, Palmer, Huria, Lacey, and Wilkinson (2018) determined were the most likely of cultural safety education training programs to enhance and transform participants' practice. Indeed, anecdotally, since the *Biigiweyan* pilot, individual practitioners have reached back to members of the Research and Project Coordination Team for support in further training. In this regard, the shared responsibility of individual practitioners and administrators working in positions of power in the helping professions cannot be understated.

Finally, it is anticipated that the process of developing *Biigiweyan* has also led to strengthened relationships between the postsecondary institutions and local Indigenous communities on whose land Canadore College operates. This project represents an important contribution towards answering The Truth and Reconciliation Commission's (2015) Call to Action #24 surrounding the need for skills-based training education to influence positive change within the helping professions in Canada.

## Conclusion

The concluding message from this work is that a true and fulsome understanding of the service user's cancer journey experience involves an understanding at all levels: distal, intermediate and proximal. *Biigiweyan* asks that participants engage in a 'coming home' and appreciation of the power of understanding the self in these learning contexts.

Reflective of the focus of this Special Issue, these examples illustrate key elements of cultural safety in action; namely, the encouragement of reflexivity and self-awareness of emerging trainees; the centring of Indigenous Peoples' understandings of colonisation in relation to their present experience of the helping professions; and an overarching reminder that decisions about whether an interaction with a service provider is culturally-safe are ultimately determined by those receiving services.

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