Developing Elders Support for Trauma Informed Emergency Departments (DESTINED)

Final Report

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&

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Project Summary

Background

- The project was funded by CIHR in 2016 with input from the Heron People Circle (Royal Roads University Elders and Old Ones), Dr Elizabeth Hartney, Asma-na-hi Antoine, and Island Health. Nadine Charles provided Indigenous consultation through the earlier stages of the project, before her tragic passing in 2019.
- Elders were finding the hospital environment so re-traumatizing that they were choosing not to seek treatment, resulting in untreated injuries, and potentially preventable illnesses and deaths, while others reported receiving sub-standard care.

Project Goal

The goal of the DESTINED project is to overcome perceived barriers to Indigenous Elders accessing hospital based emergency care.

How the Grant was Used

The grant paid for honoraria and for gifts to Elders and One Ones, for a team of Indigenous students and researchers to work on the project, for training and conference attendance including travel to Port Alberni for meetings, and for transcription and report production services. We paid Elders to attend talking circles in Port Alberni and individual interviews in Victoria.

Results and Recommendations

Our results identified positive and negative experiences of hospital emergency departments, we developed the following recommendations for Island Health

- Develop policy to eradicate overt racism from hospital emergency departments.
- Develop and implement trauma-informed practice in Emergency Departments.
- Provide cultural safety training for emergency room/hospital staff/physicians.
- Create advocate positions and raise awareness of existing supports, and strengthen relationships between hospital, community and First Nations organizations.
- Support ongoing Elder Gatherings to support work around addressing health system changes.
- Strengthen relationships between hospital, community and First Nations Health Service organizations.
- Display the United Nations Declaration on the Rights of Indigenous People in Emergency Departments.

Executive Summary

This report describes a Canadian Institutes of Health Research (CIHR) funded project, which was conducted with Indigenous Elders living in two communities on Vancouver Island, British Columbia, from 2016 to 2020. In this report, the terms Indigenous, Aboriginal, First Nation, Nation, status and non-status are used interchangeably. This report reflects the voices of a large number of Indigenous contributors (see DESTINED Project Team), as well as the voices of the Elder participants.

This project concerns what has been identified as the most important topic for Canada (Trudeau, 2019) and the most important topic for Canadian health leadership (Dagnone, 2016). The Great Canadian Healthcare Debate. National Health Leadership Conference, Ottawa, ON., 2016): the health of Canada's Indigenous peoples, specifically Elders. Originating from one of the First Nations communities involved, and the response of the regional health authority, the issues addressed by the research is that many Elders are not accessing necessary emergency medical care due to issues of past traumatization in the healthcare system. In the context of enduring health disparities for Indigenous peoples (King, Smith, & Gracey, 2009; Mitrou et al, 2014), and an aging population, this poses significant health and mortality risks for this vulnerable population. Through recommendations developed through this project, the health system will be better equipped to bring about the necessary changes to address the healthcare needs of Elders. In addition to the medical vulnerability of those Elders who are seniors, as the keepers of knowledge and wisdom, Elders' choices have a profound influence on the rest of the community. If Elders do not feel safe accessing the emergency department, others in their community may be deterred from doing so, both in the present, and as they age.

The purpose of the project was to address the research question: how do Elders and Indigenous communities recommend that the health system modifies and enhances existing emergency services in order to meet the needs of Elders in a culturally appropriate, trauma-informed, way? The goal of the DESTINED project is to advance knowledge to overcome perceived barriers to Indigenous Elders accessing hospital based emergency care. Barriers may be inherent in existing healthcare systems, policies, practices, and professional training

processes. DESTINED will address these perceived barriers by developing recommendations to develop culturally appropriate, trauma-informed emergency department approaches.

To this end, we engaged with First Nations communities in Port Alberni and Victoria, and employed a team of Indigenous researchers who have strong working relationships with the communities to recruit Elders and collect data using Indigenous methodologies, including talking circles, photovoice, and narrative interviews. The project adhered to principles of Ownership, Access, Control and Possession (OCAP), and guidelines on working with Indigenous people (see appendix A).

Key findings from Port Alberni included the importance of building cultural awareness, cultural safety and humility, including an understanding of the relational and connectiveness worldview of Indigenous people; of building relationships, trust, and communication, particularly regarding medical information to the patient; building cross cultural capacity, particularly through education about Indigenous issues, and the role of ceremony in healing; and collaboration in in terms of leadership, advocacy and partnership.

Key findings from Victoria included an awareness of culturally appropriate communication, which was evident in the interviews; nuances in the ways that Elders described positive and negative experiences of care, which reveal a need to apply a patient-centred orientation, consistent with provincial policy (Ministry of Health, 2013); a disregard for family relationships; and the need to attend to repeated admissions due to trauma, such as gendered violence, indicating the need to implement trauma-informed care (Centre of Excellence for Women's Health & Ministry of Health, 2013) in emergency departments.

Recommendations include: (1) Develop a health authority wide, and provincial policy, to eradicate overt racism from hospital emergency departments; (2) Develop and implement trauma-informed practice in Emergency Departments which addresses the needs of Indigenous people; (3) Promote appropriate cultural safety training for emergency room/hospital staff/physicians and advocate for this to become mandatory; (4) Work in collaboration with First Nations community health staff and health service organizations to establish advocate positions, and increase awareness of nursing support; (5) Support ongoing Elder Gatherings to

support work around addressing health system changes; (6) Maintain efforts to strengthen relationships between hospital, community and First Nations Health Service Organizations; (7) Create a public display of the United Nations Declaration on the Rights of Indigenous People.

1.0 Background

This project concerns what has been identified as the most important topic for Canada (Trudeau, 2019) and the most important topic for Canadian health leadership (The Great Debate, 2016): the health of Canada's Indigenous peoples, specifically Elders. Through our consultations with Indigenous communities and Elders, it has become clear that many Elders are not accessing necessary emergency medical care due to issues of past traumatization in the healthcare system. This is consistent with a recent scoping review, which addressed the needs of Indigenous patients in the emergency department more generally. The need to provide emergency department cultural humility and safety initiatives, to develop post-colonial understanding and partnerships with local Indigenous communities, to provide practitioners with competencies in relationship-building and self-awareness, to orient emergency department resources and services to meet the needs of patients with limited access to non-emergency healthcare, and to aim to prevent discrimination, were identified as recommendations (Berg et al, 2019).

Literature on how to address the problem of inadequate access to culturally appropriate emergency healthcare for the population of Indigenous Elders is scant. Literature on seniors' health points to the importance of emergency departments to provide essential, often life-saving care to older adults (di Bari et al, 2015), and to provide prevention and education interventions to address future needs, such as risk screening for functional decline (Sirois et al, 2017). Excellent work on emergency care for seniors, such as that conducted by Faul et al (2016) and Choi, DiNitto, Marti, & Choi (2016), have identified the healthcare needs of seniors. Yet this body of literature fails to identify how to meet the specific needs of Elders in creating an emergency health system that addresses the needs of the whole population of older adults, and their appropriate trauma-informed care. Within Indigenous literature, scholars such as Yellow Horse Brave Heart (2004), and the Report of the Truth and Reconciliation Commission of

Canada (2015), have focused on identifying past trauma in Indigenous peoples – however, none of these works have addressed the central question of the specific social, cultural, and psychological dimensions of what is needed to make the healthcare system feel culturally appropriate, trauma-informed, and acceptable to Elders.

This gap in knowledge urgently needs to be addressed. As the Canadian population ages, the healthcare needs of Elders will continue to multiply. Without adequate knowledge of how to meet these growing healthcare needs, health inequities, along with preventable suffering and loss of life, will continue. This project addresses this gap by providing insights into the development of trauma-informed emergency departments within hospitals, from the perspectives of Elders, as well as their families and communities.

1.1 Organizational Context

The current project was initiated by a meeting with Island Health, Principal Investigator, and the Indigenous Student Services Manager, during which the health authority reported that Elders in one of the First Nations communities the health authority served were avoiding use of the emergency department of West Coast General Hospital, due to re-traumatization. The health authority consulted with the community, the hospital involved, and the First Nations Health Authority, and recommended seeking funding for a CIHR project grant to support development of a patient-centred initiative to address this issue.

The Indigenous Student Services Manager approached the Heron People Circle (Elders and Old Ones, the caretakers of cultural wisdom, who support faculty, staff, and students by weaving together traditional and western practices), who met with the Principal Investigator, and the Manager of Indigenous Education and Student Services and provided support and input into the project. Their input emphasized the need to provide appropriate emotional support during the research process, and that Elders should not be required to retell traumatic stories. Rather, it was collectively determined that the most appropriate approach to the research would be to engage with the First Nations communities to develop a vision and strategy for developing welcoming, trauma-informed, culturally appropriate healthcare services, that would feel safe for Indigenous peoples to access. The Elders also identified the need for education to ensure that Elders and other community members understand the advantages of accessing

emergency care when they are injured or critically ill. Given the short timeline for application, the Elders wished to proceed with the project application, focused on their own communities (surrounding Victoria), while continuing to work towards collaborating with the original community, the regional health authority, and the First Nations Health Authority. With the strong working relationship between the university, the Elders, and the First Nations communities, the research team will continue to listen to and honour their guidance, with the intention that their narratives can work towards positive change in the healthcare system.

Once a bridging grant had been awarded, an Indigenous Research Associate who was also a student in the MA Leadership (Health Specialization) program was engaged from the Port Alberni area to gather data in that community. Additional Indigenous Research Associates were employed and contracted to work on the project, one of whom gathered to data in the Victoria community.

The population of the Alberni Local Health Area (LHA) is 30,456 with 9.22% of the population 75 years or older (Island Health, 2018a). In contrast, the total population of Vancouver Island is 793,180, with 10 % of the population 75 years or older. The Indigenous population of the area is more than double that of the total Vancouver Island population, with 2016 census information indicating that 19.9% of the Alberni LHA identify as Aboriginal, compared to 7.6% in Vancouver Island as a whole. Port Alberni residents have a life expectancy of 79 yrs, three years lower than the regional average of 82.2, and also have higher rates of death due to chronic conditions (Island Health, 2018a). These data do not include on reserve population information. The on-reserve population estimate for Vancouver Island First Nations is approximately 17,320 based on calculations from Indigenous and Northern Affairs Canada (INAC) First Nations Profiles that include 2016 Census information. Approximately 12% of on-reserve populations are over the age of 65.

Vancouver Island region is comprised of three distinct First Nations cultural families: Coast Salish, Kwakwaka'wakw and Nuu-chah-nulth. There are also three First Nations Health Service Organizations that provide health programs and services directly to the majority of the First Nations in the region. Island Health has acknowledged inequities in the health system and, through the Partnership Accord, is committed to addressing them in a meaningful way.

Island Health has been making efforts to increase awareness and understanding of cultural safety, humility and competency among their staff. They have developed a regional specific curriculum and have recruited a small staff to assist with advancing the interest of achieving goals set out in this area of priority (Island Health, 2018b, p. 13). The context of this inquiry can support the broader goals of building internal capacity of Island Health staff as it relates to the higher-level commitments of the organization.

Although Island Health has established local Aboriginal Working Groups, and an Aboriginal Health Council, that provide a mechanism for local service planning specific to Aboriginal People, there is no consistent approach to engagement as it relates to emergency care services or local service planning specific to Aboriginal People. That being said, FNHA has established 11 cultural safety committees centered around acute care centres across Vancouver Island. These are coordinated in partnership with Island Health Aboriginal Health Managers and local site staff. These committees are intended to strengthen relationships between hospital staff and local area First Nations Health Directors/Health Service Organizations to support a localized approach to addressing issues of concern.

1.2 Literature Review

Health disparities are still a major issue for Indigenous peoples (Anderson et al., 2016). A study by Mitrou et al (2014) showed that in spite of Canada's advanced development in many domains, Indigenous peoples in Canada were almost as disadvantaged, and in some cases, more disadvantaged in the social determinants of health, in 2006 as they were in 1981, compared to the Canadian non-Indigenous population. New approaches for closing gaps in social determinants of health are required if progress on achieving equity in healthcare is to improve; the DESTINED project represents such an approach.

Distrust between Indigenous Canadians and the medical establishment remains a major driver of health inequities, with the emergency department being the most significant point of contact between Indigenous peoples and the medical system (Vogel, 2015). Historical trauma in the form of abuse, coercion, and family separation forced on Indigenous peoples within the health system cannot be separated from ongoing health disparities. The phenomenon of historical trauma, defined as "the cumulative emotional and psychological wounding, over the

lifespan and across generations, emanating from massive group trauma experiences" (Yellow Horse Brave Heart, 2004, p. 7), has emerged from decades of clinical practice with and observations of Indigenous peoples, as well as preliminary research.

King, Smith, and Gracey (2009) have identified many underlying causes for the health discrepancies between Indigenous peoples and their non-Indigenous counterparts in the Canadian population. In addition to the social determinants of health, the health system is built upon non-Indigenous concepts of illness, which contrasts with the broader Indigenous concepts of physical, emotional, mental, and spiritual wellness; such concepts recognize the importance of living in harmony with others, with their community, and with the spirit world, all of which are neglected in the mainstream Canadian healthcare system.

Hutten-Czapski (2014) argued that the predominantly non-Indigenous healthcare professionals who treat Indigenous peoples might attribute poorer health outcomes for Indigenous peoples to a lack of compliance with prescribed health behaviours. He went on to propose that when considering conflicting world views and value systems, at some point the non-Indigenous system has to recognize the value of Indigenous perspectives, and the need to change, in order to meet the needs of this vulnerable population.

Several barriers to accessing health services have been identified in our consultation with the Elders, and are supported by the literature. These include the location of First Nations communities in rural and remote areas, with long travel distances required. At the point of care, fear is generated and reinforced through past and ongoing experiences of racism, unfair treatment, and feelings of isolation. There are also barriers such as limited access to comprehensive and specialized care, long waiting times, communication and understanding of medical jargon, and the negative interactions with health care professionals, including emergency department health care professionals' judgmental behaviors toward them (Cameron et al, 2014). Gibson et al's (2015) research has shown that access to healthcare by Indigenous peoples is facilitated by employing Indigenous workers, both as healthcare providers and in reception, paramedical, and administrative positions, providing services in culturally safe spaces, and recognizing and accepting the supportive role of family in a patient's

care. The idea of having an Indigenous person present within the hospital setting was independently suggested by the Elders.

Elders can be distinguished from elderly people, both of whom are important in Indigenous communities. In Indigenous communities, Elders are individuals who have shown wisdom and leadership in cultural, spiritual, and historical matters within their communities, and may or may not be seniors. Although the proportion of older adults in Indigenous populations is smaller than in the non-Indigenous Canadian population, that proportion is growing. Data from the 2006 census also revealed a trend toward aging within the Indigenous population; the number of Indigenous peoples aged 65 years and older increased by 43% that year (Gionet & Roshanafshar, 2013).

Elders provide a connection with the past, as keepers of community knowledge and supporters of its collective spirit (King, Smith, & Gracey, 2009). It is, therefore, doubly significant to the health of Indigenous communities if Elders do not access emergency departments, as their decisions, and the way they discuss their decisions, can potentially influence the ways of thinking about healthcare, and the healthcare decisions of the whole community. Although social support structures within First Nations communities can promote healthy behaviours, research with Canadian First Nation and Inuit Community Health Representatives has revealed that the conformity and dependencies that can be promoted within the community, and imposed by socio-economic circumstances, can also lead to health damaging behaviours (Richmond & Ross, 2008), of which this may be an example.

1.3 Rationale

The rationale for the DESTINED project is that a greater understanding of the perceived barriers to Indigenous Elders accessing emergency services is urgently needed, given local recognition of the avoidance of emergency services by Indigenous Elders, the significant health disparities that exist for Indigenous peoples (Anderson et al, 2016), and the potential risks of lack of access to emergency department services to seniors (Choi, DiNitto, Marti, & Choi, 2016). Through this project, the health system will be better equipped to bring about the necessary changes to address the healthcare needs of Elders.

In addition to the medical vulnerability of those Elders who are seniors, as the keepers of knowledge and wisdom, Elders' choices have a profound influence on the rest of the community. If Elders do not feel safe accessing the emergency department, others in their community may be deterred from doing so, both in the present, and as they age.

Access to health services is also an important factor in Indigenous peoples' health equity. While First Nations communities tend to be located in rural areas, with long travel distances to healthcare services, access is impacted by numerous factors in addition to the physical availability of health services to the community. Such access is also greatly influenced by how healthcare services are delivered at point of care, with Indigenous peoples reporting racism, stigmatization, language difficulties, intimidation, harassment, and deep fear when accessing emergency department health services.

2.0 Project Purpose, Goal, Objectives and Outputs

The purpose of the project was to address the research question: how do Elders and Indigenous communities recommend that the health system modifies and enhances existing emergency services in order to meet the needs of Elders in a culturally appropriate, trauma-informed, way?

The goal of the DESTINED project is to advance knowledge to overcome perceived barriers to Indigenous Elders accessing hospital based emergency care. Barriers may be inherent in existing healthcare systems, policies, practices, and professional training processes. DESTINED will address these perceived barriers by developing recommendations to develop culturally appropriate, trauma-informed emergency department approaches.

The objectives of the DESTINED project are to:

- Follow appropriate protocols in building trusting, collaborative relationships with First Nations communities, with the intention on working together towards the project goal;
- Engage with Port Alberni and Victoria First Nations communities, in a culturally appropriate and sensitive manner;

- Recruit Indigenous researchers Indigenous researchers who have strong working relationships with the communities from within each of the communities, who will recruit participants and conduct the research, who will form a collaborative research team with the Principal Investigator, Elders, and collaborators;
- Provide any required training to enable the Indigenous researchers to be fully involved in the processes of analysis and interpretation of the data, the development of recommendations, and the dissemination of findings;
- Provide appropriate supports, as necessary, to ensure communities are not harmed or burdened by engaging in the research, and that any psychological concerns raised by research participation are fully and adequately addressed by the means considered most appropriate to the participant (i.e. additional Elder support, Indigenous psychological services);
- Consult with Elders and Knowledge Keepers at all stages, to ensure maximum benefit to the communities involved.

The project outputs are:

- Recommendations for the healthcare system on developing culturally safe, culturally appropriate, and trauma-informed emergency department services to meet the needs of Elders.
- A plan for implementation with the regional health authority, and advice to the First Nations Health Authority and the Ministry of Health on provincial dissemination and implementation.
- Enhanced knowledge on best practices for engaging in collaborative healthcare research with Indigenous peoples, in the form of publications and educational offerings, which are integrated into current opportunities, such as the MA Leadership (Health Specialization) curriculum, and additional development, such as online and in-person continuing education courses for healthcare leaders, health researchers and healthcare professionals.

3.0 Methodology

The project draws on a combination of Indigenous methodologies (Wilson, 2008), particularly the Nuu-chah-nulth perspective (Atleo, 2011), use of local Indegenous interviewers (Elliott, Watson, & Harries, 2002), action research engagement (Rowe, Graf, Agger-Gupta, Piggot-Irvine & Harris, 2013), and phenomenology (Smith, 1996; Smith 2004).

3.1 Ethical Considerations

As an Indigenous project, the research team has upheld the principles of Ownership, Access, Control and Possession (OCAP) throughout the whole process of inquiry. The development of the research was at the direction of community members to address specific concerns of care at West Coast General Hospital, and was extended to the Victoria community in response to feedback from the Heron People Circle. The research team have ensured that research participants had the opportunity to validate their contributions following each data collection session and a review prior to finalization of this report. Further to this, participants were provided with copies of all reports (including this report) arising from the research.

Research Ethics Board (REB) approvals were co-developed by Indigenous Research Associates in consultation with their communities, and received clearance from Royal Roads University REB and Island Health REB prior to the commencement of data collection.

During the course of the project, Royal Roads University has developed Guidelines on Research Involving Indigenous Peoples; the process was led by the Indigenous Student Services Manager and the Principal Investigator was a contributor (see appendix A). The project has adhered to these guidelines.

3.2 Project Team Recruitment, Training, and Development

The project team was recruited primarily through pre-existing relationships. All except one Research Associate were recruited by team members who were aware of their strong connection to Indigenous communities. While advertising through the university human resources department was used to recruit one Research Associate, she was known to another team member who recommended her as knowledgeable about and trusted by the community.

The two Indigenous Research Associates who collected the data both had long-standing professional relationships, through their employment with the First Nations Health Authority, which facilitated the process of engaging with participants. For one, having access to all stakeholder tables within the region combined with her role as an MA Leadership (Health Specialization) student, positioned her well to engage in research on which to base her thesis (Joe, 2019).

3.3 Recruiting the Samples

Two samples of participants were recruited for the project: one sample from Port Alberni, and one sample from in and around urban Victoria. In recruiting the Port Alberni sample, the Indigenous researcher who was recruiting participants and gathering data is a lifelong, member of the community, and is well known to community members due to her role within the First Nations Health Authority. She utilized existing Health Director/Elder Worker contacts and First Nations Health Authority Community Engagement networks to assist with identification of Elders interested in participating in order to obtain a broad sampling of local area First Nations Elder input. The geographic location of this inquiry included her home community and close familial relationships. Her approach to engage First Nations Health Directors/Elder Workers to identify participants was intentional to mitigate any real or perceived conflict of interest. Once Elders were identified, she reached out to them directly to discuss the inquiry and provide background information. She had pre-existing work relationships with most Elder participants which fostered a level of comfort for participation. A written invitation was used to support recruitment, which noted one to two Elders per from each of the five local area First Nations communities to keep the project within a manageable scope in recognition of the magnitude of the topic area; however, this was later expanded to include Elder family supports. Where a Nation requested additional participants, the request was supported. Recruitment of sufficient participants to engage in the talking circles and photovoice took an extended period of time, requiring extensions to the project. Impacts of community loss and Elder illness resulted in low participant numbers in the first photovoice session.

In recruiting the Victoria sample, the Indigenous researcher who was recruiting participants and gathering data is a member of the community, originally from another nation on Vancouver Island, and married in to one of the local First Nations. He is well known to community members due to his role within the First Nations Health Authority. All participants were known to him personally; he approached participants individually and verbally invited them to participate in the project. A video explaining the background, purpose, and requirements of the project, which was developed by another Indigenous Research Associate from the local community, was used to assist with explaining the background to the project.

3.4 Participants

The first sample of participants were from the Port Alberni area. They included First Nations Elders from First Nations communities whose primary access point for emergency services is the West Coast General Hospital in Port Alberni, including Tseshaht, Hupacasath, Uchucklesaht, Huu-ay-aht and Ditidaht. For the purpose of this study, participant criteria were set as one to two Elders, age 60 or older, from each of the local area First Nations communities. 60 years old is the age that Tseshaht and Hupacasath members are eligible for Elder benefits from the Nation. Elder participants received a half-day honorarium ($150) in acknowledgement of their time and expertise shared to inform the work. Further to this, counselling services and cultural supports were readily available for any participants who may have experienced emotional reactions as a result of their participation.

The Elders talking circles included a total of eleven participants (three male and eight female) with representation from each of the five noted First Nations. Early efforts to coordinate talking circles were challenging for a number of reasons. The first talking circle had three participants from one Nation, the second talking circle had eight participants with representation from all five Nations. It was necessary to provide deeper context to the history of the project and to further explain the research process prior to the talking circle. Participant invitations for the photovoice data collection were expanded to include Elders and their family supports based on dialogue from the talking circle data collection. There were two participants (both female) from two Nations in the first session and, five participants (four females and one male) with representatives from five Nations.

As the research question specifically looked at supporting improved access for First Nations Elders, a purposeful sampling approach (Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood, 2015) and snowballing technique (Goodman, 1961) were used to recruit Elders into the Port Alberni sample.

The final phase of the Port Alberni research was a collaborative action planning session with Island Health geography leadership, West Coast General Hospital Senior Site Staff, Nuu-chah-nulth Tribal Council (NTC) Nursing Staff and FNHA Management and Engagement Staff. We employed a sampling approach of identifying key people (Stringer, 2014, p.79), which was held at the Tseshaht Nation in Port Alberni. This was to ensure that individuals in positions of influence within West Coast General Hospital, particularly emergency care services were included in the collaborative action planning.

Ten Elders participated in the Victoria sample, which included Elders from Scia'New, T'Sou-ke, Esquimalt, Songhees, and Tsawout Nations. These nations are served by emergency departments at the Victoria General Hospital, the Royal Jubilee Hospital, and the Saanich Penninsula Hospital.

3.5 Data Collection

Data collection methods were talking circle and photovoice (Port Alberni), and individual, narrative interviews (Victoria). Handwritten notes were used to record data from the talking circles and photovoice, and the interviews were transcribed verbatim.

The talking circle method was used to provide an opportunity for First Nations Elders to articulate what supports they would need and/or welcome to participate in the research inquiry. It was important to include this method to inform data collection that followed. Talking circle is a narrative and relational approach that has been utilized by Indigenous populations as a means of teaching, listening and learning (Running Wolf & Rickard, 2003). Historic applications have been used to obtain consensus-based decision-making (Aserson, Greymorning, Miller & Wilde, 2013), to build a sense of community, as well as used as a form of ceremonial or spiritual healing (Wilbur, Wilbur, Tlanusta Garret & Yuuhas, 2001). Pranis (2005)

noted use of the circle to gather as a community to solve problems, support one another and connect to each other. This method served to create learning opportunities for both participant and facilitator. Notably, the nature of design created a safe space for open communication and sharing, and encouraged listening and empathy.

Although intended as an integral part of the overall method, due to lack of photo contribution by participants, photovoice mainly served as an opportunity to generate dialogue among local First Nations Elders and their family supports on what wellness and good health care means to them. This method placed a level of control with the research participants and was an innovative and creative way for individuals to share their unique perspectives and experience though visual and narrative means that support articulation of more in depth context to the matter at hand (Stringer, 2014). Tuhiwai Smith (1999), in speaking of historical practices of research, noted the Western influence on data collection, interpretation and knowledge translation. This practice detracts from Indigenous ways of knowing, being and doing.

Thematic analysis was used to analyse the data (Braun and Clarke, 2006). In addition, relational accountability was used when analyzing the talking circles (Wilson, 2008, p. 119) in an attempt to bridge cultural gaps between Western and Indigenous ideology, and interpretative phenomenological analysis was used when analyzing the interviews (Smith, 1996), in order to develop insights into the experiences of Elders accessing emergency departments.

The final phase of the Port Alberni research included use of a graphic facilitator to develop a visual representation of the collaborative action planning dialogue. In recognition of the context of this project that addresses experiences of care within First Nations populations, it was important to include methods that were reflective of meaningful and culturally appropriate participation.

3.6 Data Analysis

The research team ensured that the data analysis was grounded in an Indigenous paradigm (Wilson, 2008), and honoured the lived experience of First Nations engaging with a

health system that is not aligned with their own axiology and ontology. In addition, an Inquiry Team comprising two members of the Tseshaht First Nation assisted with data analysis, and review and feedback on findings, conclusions, and recommendations.

3.7 Validation of the Findings and Recommendations

The results of the Port Alberni research were validated through a presentation given by the Indigenous Research Associate who had conducted the talking circles, and discussed at the collaborative planning session held at the Tseshaht First Nation. The analysis of the interviews was validated individually with participants by the Indigenous Research Associate who had conducted the interviews.

The recommendations of the Port Alberni research were discussed with West Coast General Hospital leadership in a series of follow up meetings with the research team. In addition, the recommendations of the Victoria research were discussed with Victoria General Hospital leadership in a follow up meeting.

Finally, the findings were shared with the Royal Roads University Heron People Circle, who had originally supported the research.

4.0 Key Findings

The findings of the project are described in more detail elsewhere (Joe, 2019; Hartney et al, forthcoming). For the purposes of this report, the key findings from both locations will be described.

4.1 Port Alberni

4.1.1 Building Cultural Awareness, Cultural Safety and Humility

Information gleaned from all phases of research touched on the importance of cultural awareness. First and foremost is the need to understand that First Nations are the People of the land, they are connected to the land, water and resources. All talking circle and photovoice participants had a relational approach to their responses, consistently reflecting familial, and community connections, connections to traditional lands and resources, and connections to spirit and ceremony. Although the focus of the project was Elders, participants did not isolate

their own experience from that of their parents, grandparents, children, grandchildren and extended family members.

Participants asserted their understanding of impacts of colonization, including the intentionally exclusionary and oppressive education, health, governing and economic systems that were put in place in attempts to assimilate First Nations, and are in direct opposition to First Nations traditional ways of being. The need for cross-cultural sharing was identified, to gain deeper understanding of health systems and processes, and to provide opportunity to health service providers to gain deeper understanding of First Nations People, culture, and lived experience that influence how they interact with the health system. This was identified as a shared responsibility of First Nations and the health system.

4.1.2 Building Relationships, Trust, and Communication

A core tenet of the Nuu-chah-nulth teaching of heshook-ish tsawalk is relationship. Isaak (Respect) is foundational to building relationships and trust. Elders reminisced about long established traditional practices of taking children to visit grandparents, Elders, and extended family members. Children were taught to help their Elders where it was needed, and to be kind to one another, supporting and developing relationships within and across communities, and contributing to a sense of belonging and worthiness. Colonial practices broke relational bonds between children and their families for generations. The collective lived experience of Elders in education and health care systems has created a high level of distrust in the system. Elders described multiple incidents of being treated disrespectfully in emergency care services and the broader health care systems. This has impacted how First Nations Elders interact with the health care system, leading to avoidance of medical assistance until health conditions deteriorate to a point of complexity or fatality. The lack of respect undermines self-worth and Elders' openness to express concerns when incidents of racism, prejudice or assumptions occur, leading to breakdowns in communication.

Communication has significant impacts on relationship building and trust, particularly in relation to personal interactions within family/community as well as between service providers and patients, and between health service providers and organizations. Elders

commonly felt that communication is very low in the health system, with patients sometimes waiting for hours on end with no explanation of what is going on and without any hospital staff checking in on them, and that that often medical procedures, prescriptions and processes are not communicated, which leads to uncertainty, lack of understanding and negative experiences in the health care system. Increased communication could provide clarity on processes and procedures in a manner that would foster trust and build relationships with health service providers. First Nations come from an oral tradition where teachings were passed from generation to generation through stories, and children or others know what to expect. Understanding a First Nations world view where community leaders are looked to for guidance, health service providers would also be looked to for that guidance in the context of interactions with the health system.

4.1.3 Building Capacity

Data analysis showed that building capacity at an organizational and individual are of equal importance. In an organizational context, there was strong feedback from participants about creating space for cross-cultural orientation. Hospital staff and health service providers need education and awareness of who the local area First Nations are – respecting and acknowledging traditional territories. Another common theme among all participants was the need to increase education and awareness of First Nations, particularly Nuu-chah-nulth history and lived experience.

There were numerous references throughout the talking circle and photovoice data that related to the need to increase awareness and understanding of various health conditions, and nutrition, to the benefits of traditional foods and the need to advocate for incorporating traditional foods into hospital meus. Participants also identified the need for culturally appropriate resource material as well as education and awareness to support self-empowerment.

The majority of participants noted the need for healing historical traumas, and that the resiliency and strength of First Nations People is rooted in cultural practices and

ceremony; personal experiences of ceremonial practices supporting positive health outcomes were shared.

4.1.4 Collaboration

Collaboration is a key theme that arose out of the thematic analysis; particularly collaboration in in terms of leadership, advocacy and partnership. Leadership relates to traditional First Nations familial and community leadership, as well as leadership of hospital, regional health authority and Health Service Organization staff to make changes. Participants shared past First Nations Leadership strength in upholding traditional values and teachings to look out for the best interests of their People. The Western medical system, as it currently exists, lacks cultural awareness to accommodate a holistic approach to health and wellness; rather it is set up to protect individual patient privacy and confidentiality, which can sometimes exclude practices that could support individual wellness. Other aspects of leadership included hospital site and health authority staff leadership in addressing negative experiences of care; honest acknowledgement of racism, discrimination, and judgements made in relation to service provided to First Nations patients are needed, and steps to change policies and procedure to address negative attitudes, assumptions and stereotypes.

The need for First Nations political and health service organization advocacy was identified; Elders traditionally fulfilled this need in the community.

Many references were made to how partnerships can contribute to wellness. Partnerships include working with organizations or individual First Nations communities working with hospital staff. Themes emerging from the data included partnership with agencies or organizations in areas connected to social determinants of health, including, but not limited to: educational institutions, RCMP, child welfare, social housing, long term care homes, hospice and palliative care.

4.2 Victoria

4.2.1 Culturally Appropriate Communication

The rapport developed by the Indigenous interviewer during the narrative interviews with Elders, that was evident in the interview transcripts, demonstrated an awareness of, and

skills in culturally appropriate communication with Indigenous Elders. This included taking an interest in Elders' families, while sharing personal information about his own family, as well as referring to his own personal experience to demonstrate empathy with Elders as they told their stories, and rapidly built trust within the interview process. Such a style of communication would greatly support Indigenous Elders presenting in emergency. However, this approach runs counter to typical Western professional culture, particularly in healthcare, in which little to nothing is revealed about professionals' personal life to patients.

4.2.2 Experiences of Care

Stories of both positive and negative experiences of care were shared by many Elders. However, a nuance in the ways that Elders described positive and negative experiences was that negative experiences focused primarily on how the interaction, or lack of interaction, with healthcare staff made them feel. These negative interactions included healthcare professionals communicating in a paternalistic, condescending manner, in some instances talking to the Elder as if they lacked intelligence or did not know what they were talking about, in other instances, directly verbalizing these opinions due to the Elders' "Indian" status. Communication was directive and constraining, rather than empowering, for example, an Elder already in a psychologically vulnerable state due to suicidal ideation was further distressed by being told he would not be allowed to leave unless he consented to medication he did not wish to take; instead of being supported and empowered he was left feeling captive. In contrast, positive experiences focused instead on the medical and technical aspects of care, such as the fact that the hospital saved their life, rather than positive interactions with staff. Other common negative experiences included being assumed to be drunk and feeling they were having to wait longer than the white people who were there.

4.2.3 Disregard for Family Relationships

Participants described experiences of their families being unwelcome in the hospital. This was challenged when advocates were aware of the right of patients to have family visitors, however, without this insider knowledge, patients were left feeling isolated.

4.2.4 Repeated Admissions Due to Trauma

Stories of having to repeatedly attend emergency due to ongoing gendered violence reveal a need for greater sensitivity and supports in the emergency department. Similarly, sexual violence and suicidality were discussed. These extremely traumatic experiences reveal the need for trauma informed practice.

5.0 Implementation Plan

5.1 Discussion

The talking circles and narrative interviews reveal that disrespectful and inappropriate treatment in the emergency department is commonplace among Indigenous Elders. In some instances, overt derogatory references were made to “Indian” status. This is inexcusable and needs to be addressed immediately.

Other aspects of care could be improved with staff training, particularly on the subjects of cultural safety, trauma-informed practice, and patient-centred care. Online resources are readily available in British Columbia, and the Ministry of Health has a policy on patient-centred care which runs counter to the way that Elders reported being treated in emergency departments. It is imperative that this policy is communicated, and that procedures are developed to support its implementation.

5.1.1 Implementation at the hospital level

Eight key recommendations were made to the health authority regarding implementation at the West Coast General Hospital in Port Alberni. These fall into three categories: recommendations that have been implemented; recommendations in the process of being implemented; and recommendations that cannot be implemented due to further research or resources being required.

Recommendations that have been implemented are promotion and support cultural safety training for all Island Health employees including direct patient care employees both in hospital and community settings. Continued promotion of cultural safety training is an Island Health initiative across the board and is reflected in their 2020 – 25 Strategic Framework (not yet published). Goal 1: Improve the Experience, Quality and Outcomes of Health and Care

Services for Patients, Clients and Families. Objective 1.2: Island Health will seek to reconcile relationships with Indigenous peoples living within the Island Health service region. As such continued training of Emergency Room and Hospital staff is essential to meet the strategic priorities of Island Health overall. San'yas online cultural safety training is a core requirement for all new staff orientation. However, cultural safety training is not currently mandatory for existing staff. This is in spite of feedback from Elders and researchers at the Collaborative Planning Session requesting it become mandatory. The health authority is hesitant to mandating training, due to concerns that it could be counter-productive if longer-serving staff feel forced to take education they do not relate to, and may react against messages of the training, resulting in a less culturally safe environment for Elders. Number or percentages of staff who have engaged in the training are not available for this report.

Action has been taken regarding education and awareness of Aboriginal Liaison Services and scope of work. This is included as part of the daily integrated team meetings that take place every morning (Monday – Friday). This position is part of the structured team report. Aboriginal Liaison Nurse and Nurse Navigator Services are promoted through the West Coast General Hospital Cultural Safety Committee. Both positions are included as committee members. Finally, a First Nations Health Authority/Island Health (Joint Project Board funded) Nurse Navigator position, administered through the Nuu-chah-nulth Tribal Council, is now included in the structured team report meetings as well as home and community care meetings.

Implementation of several recommendations are underway. These include West Coast General Hospital continuing to work with the Nuu-chah-nulth Tribal Council to develop localized First Nations cultural orientation for hospital staff. West Coast General Hospital is working in ongoing partnership with the First Nations Health Authority in the coordination of monthly Cultural Safety Committee meetings to increase understand of local area First Nations, build stronger relationships, identify localized solutions for concerns raised regarding the West Coast General Hospital patient experience. This Committee supports participation of 5 local area First Nations, Nuu-chah-nulth Tribal Council, Port Alberni Friendship Centre and Kuu-us Crisis Line Society. West Coast General Hospital has been identified as potential next site for expansion of

the First Nations Health Authority/Island Health Elder in Residence position. Currently the position has been implemented in the North Island Hospital Campuses. There is a strong partnership with First Nations Health Authority on this project and planning is underway. West Coast General Hospital continues efforts to strengthen relationships between hospital, community and First Nations Health Service Organizations through the established Cultural Safety Committee, and consider integration of services where opportunity arises. Signage, including a public display of the United Nations Declaration on the Rights of Indigenous People, is on the agenda for the February/March 2020 West Coast General Hospital Cultural Safety Committee Meeting agenda. The committee will look at establishing a Working Group to address signage.

Implementation that is being deferred, due to the need for more data, relationship building, resources, or funding, include a Nursing Exchange. This will require a complex response to address a number of areas to ensure success of the initiative. Nurse staffing levels have been an ongoing challenge; a number of current positions are filled with agency nurses, who are outside of the general staffing pool. In order to proceed with implementation of an exchange program, staffing levels will need to be stabilized. This type of initiative will also require financial resources to accommodate back fill of nursing positions in both in hospital and Nuu-chah-nulth Tribal Council community, as well as community travel, for both Nuu-chah-nulth Tribal Council and Island Health nursing staff.

Creating a new Patient Advocate position will require financial resources not currently available within Island Health. This may be more effective if approached as a regional position, rather than a position at just at one hospital site. Island Health is currently restructuring their Aboriginal Health portfolio in recognition of Provincial and Regional commitments to address cultural safety and humility and identification of First Nations/Indigenous Peoples as priority populations. Recruitment is currently underway for a newly established Indigenous Health Executive Leadership position. Finally, support for Elder Gatherings is outside of Island Health West Coast General Hospital funding resource criteria. This will require partnership and collaboration to identify resources for implementation.

Due to delays in completing the data collection in the Victoria area, feedback on the research findings for Victoria hospitals has not yet been completed.

5.1.2 Limitations

The intent of the research team was to explore how trauma informed emergency care services can be developed at West Coast General Hospital serving Port Alberni, and three hospitals serving Victoria. The original intent was to limit participation to a small sample size (two Elders from each of the five Nations surrounding the Port Alberni area whose primary point of access for emergency care services would be West Coast General Hospital), and a total of ten Elders who accessed care at one of the three Victoria hospitals. This was to garner initial feedback to set the stage for future, more in-depth study. However, so many recommendations have emerged from this initial research (along with concurrent consultations being led by the First Nations Health Authority in the Port Alberni area, as well as broader Provincial Ministry of Health and Regional Health Authority mandates), that Island Health is no longer pursuing further research, and is instead focusing on implementation of these initial recommendations, without the rigour of validation through a larger scale study.

The recruitment in Port Alberni took an extensive period of time, and did not include outreach to off-reserve populations, while the Victoria recruitment combined on and off-reserve participants. Future study would benefit from inclusion of both on and off reserve populations and other health service providers that are mandated to provide service for off-reserve First Nations populations. Future consideration would be strongly encouraged to meet the broader Aboriginal Health mandate of the health authority that includes status/non-status First Nations, Inuit and Metis.

The population was identified at random and did not necessarily reflect a representative population, either of the Port Alberni and Victoria Indigenous populations, or of Indigenous peoples in other parts of British Columbia, Canada, and other countries affected by colonization.

The scope of inquiry was limited to emergency department services, yet participants were compelled to respond in a more holistic manner that looked at health services more broadly, including general hospitalizations, discharge planning, home care, long-term care, primary care, and chronic disease management; however, accessibility of long-term care and home care services are beyond the scope of local hospital sites. There is a broad range of underlying factors that impact accessibility of these services that would require a partnered approach to addressing as well as longer term promotion of recruitment initiatives. Addressing chronic conditions is also beyond the scope of work that can be addressed at specific hospital sites, and would require a multi-faceted approach to address

An important limitation of the study is the lack of verification of the stories of negative experiences of care to the current versus historical context. While it was clear that some of the experiences shared were recalled from years or even decades earlier, and clearly more attention is needed to restore trust in the system for Elders who lived in less enlightened times, more clarification is needed on the actual ongoing experiences of racism and poor treatment in hospital emergency departments. Recent experiences of sub-standard care, witnessed by members of the research team validate the current reality, yet future research is needed to ascertain the extent and the substance of such practices. There is an urgent need to address this concern.

5.1.3 Recommendations for Emergency Department Policy and Practice

Recommendation 1: Develop a health authority wide, and provincial policy, to eradicate overt racism from hospital emergency departments.

While some everyday microaggressions experienced by Indigenous people may be unintentional, and some insensitive treatment in emergency department may affect all people and not be specifically directed to Indigenous people, some examples of disrespectful treatment of Indigenous people were inexcusable overt forms of racism, such as referring to Indigenous patients in derogatory terms, and denying them basic rights such as contact with family members. The health authority, and the Ministry of Health, should immediately work to eradicate such behaviours at a policy level.

Recommendation 2: Develop and implement trauma-informed practice in Emergency Departments which addresses the needs of Indigenous people.

Trauma-informed practice guidelines have been developed for mental health and substance use services (Centre for Excellence for Women's Health & Ministry of Health (2013), and for children, youth, and family services (Ministry of Children & Family Development, 2017), yet they have not been developed to address the point of care at which they are most needed. Emergency departments attend to the immediate physical and psychological consequences of trauma, yet the absence of a trauma-informed approach is impacting access to appropriate care for Elders.

Recommendation 3: Promote appropriate cultural safety training for emergency room/hospital staff/physicians and advocate for this to become mandatory.

Island Health promotes and encourages Provincial Health Services Authority (PHSA) San'yas (online cultural safety training) and Island Health Next Seven Generations as necessary training requirements for all staff as well as physicians to take. However, not all staff take this training, and participants verified that First Nations Elders still have negative experiences of care at all four hospitals included in this study. As part of leadership development and capacity building, it is recommended that cultural safety training include available video resources on local First Nations history. This is key to understanding who First Nations people are and honors the traditional territories on which health staff are working. In addition to this, the video resources can be placed on public display within the hospital. This could be supplemented with training opportunities for hospital/community nursing shadowing and exchange. It would be beneficial for all hospital staff to have this opportunity.

Recommendation 4: Work in collaboration with First Nations community health staff and health service organizations to establish advocate positions, and increase awareness of nursing support.

Advocacy consistently came through as an area where focus was needed, particularly in the emergency department where patients have experienced long wait times with little to no connection to emergency room staff checking on them. Hospitals could communicate more

effectively with Aboriginal Liaison Nurses who are wonderful resource to connect with patients and their families, but are often not available when needed.

Work with local First Nations communities, health service organizations and urban Aboriginal organizations to increase education and awareness of available nursing support services. Two key services include the Aboriginal Liaison Nurses that are based in hospital and the Island Health/First Nations Health Authority shared community-based Nurse Navigator services.

Recommendation 5: Support ongoing Elder Gatherings to support work around addressing health system changes.

Historically, Elders held positions of high regard, where they were turned to for guidance and to set the tone of gatherings. Elders grounded their work in traditional knowledge and ways of being that was respectful of all. In instances that may be politically charged, there is a greater sense of calm with Elder presence and people tend to be more mindful of traditional values and protocols. Recognizing the nature of this work in bridging cultural barriers, Elders would be an asset to support a respectful approach to keep the work grounded.

Recommendation 6: Maintain efforts to strengthen relationships between hospital, community and First Nations Health Service Organizations.

Connection is key to First Nations and Indigenous world view, and fosters a sense of well-being and identity. Existing cultural safety committees are one avenue to maintain connection; however, the recommendation seeks to enhance how and when partners engage to sustain meaningful and strong relationships.

Recommendation 7: Create a public display of the United Nations Declaration on the Rights of Indigenous People.

Displaying the United Nations Declaration on the Rights of Indigenous People (UNDRIP) publicly in the hospital emergency department serves the dual purpose of informing Indigenous patients on how they can expect to be treated, and reminding hospital staff of this imperative. Out of respect, it should also be translated into the local First Nations languages.

5.2 Knowledge Translation & Dissemination

The final report will be distributed in print and online to all contributors and participants, and will be made available to Island Health employees and community members of the participating First Nations.

This report is open access published through the Royal Roads University online repository. In addition, documents such as Eunice Joe's masters thesis report (Joe, 2019), and additional publications arising from this research, will be open access published.

A presentation of the Port Alberni findings was made to Elders, community members, and collaborators at the Tseshaht First Nation in 2019. Conference presentations have already been made on the project (Hartney et al, 2018; Hartney & Rabenek, 2019). The project will be presented to the Canadian Health Leadership Network and to the Canadian Psychological Association Annual Convention in 2020. The project will be presented at the Ministry of Health *Research Rounds*, and the Royal Roads University *Roads to Research*, and copies of the report will be provided to the Ministry of Health. Further opportunities for presentations are being explored.

5.4 Recommendations for Future Research

While there is a need for a more rigorous study to take place in the locations included in this report, the responsiveness of the regional health authority to respond to the recommendations, and their recognition of research fatigue in the community, is commendable. However, numerous other health authorities recognize the need to conduct similar research to address issues related to developing trauma informed emergency departments in their hospitals, which better address the current health crises and lower life expectancy of Indigenous peoples. Therefore, this project could be used as a starting point for more in-depth research in other Indigenous communities.

Future research could focus more specifically on current experiences of emergency care, to ensure that stories of negative and positive experiences relate to current practice. Some may appreciate the opportunity to connect with a researcher interested in improving their experience and that of other Indigenous people. When interviewing, ideally, the interviewer

would ascertain at least the decade in which the incident occurred, even if the participant is unable to recall the exact month or year. Similarly, if a participant reports an incident which occurred when they were a specific age, it would be important to know the age of the participant at the time of the interview to determine its relevance to current practice.

The downside to such an approach is that in becoming more detail-oriented, the flow of the interview would be interrupted, and the content would be less on the participants' terms, and more on that of the interviewer. This would disrupt the balance of power between interviewer and participant, and may shift to becoming more colonial and Western in approach. It would be essential for the interviewer not to forsake rapport, so painstakingly developed in the current study, in their pursuit of accurate data.

It may be helpful to expand future research to explore the accessibility of community-based care for Elders, which may curtail the need to seek treatment in the emergency department, at a time of disease complexity or imminent death. This could be enhanced with partnerships with community-based health care services.

Another area of future research is to explore gender specific experiences of care. Some aspects of trauma, particularly those related to sexual assault and gender-based violence, that some may feel particularly uncomfortable talking about in front of healthcare staff of the opposite gender. This is particularly important in the context of missing and murdered Indigenous women and girls.

6.0 Conclusions

The inadequate treatment of Indigenous peoples in Canada is not in question; it is well established through decades of research indicating that the health system is failing to meet their needs, reflected in lower life expectancy and a range of health indicators. The question, then, is to identify how the emergency department is failing to meet Indigenous peoples' needs, and how to rectify this situation.

The findings from our talking circles and interviews with over twenty Indigenous Elders and their supporters indicate that in spite of experiencing mistreatment in the specific context

of the emergency department, as well as other contexts, First Nations are able to provide a wealth of insight and support which can assist the health system in this important endeavour.

Specifically, Elders consider connection to be foundational to supporting wellness. As a central aspect of Indigenous and First Nations world view, culture and ways of being, participants consistently included reference to family, community and Nation. These aspects inform a personal sense of identity and belonging, and enable Elders to feel better positioned to have a sense of self-respect and take care of themselves and others.

First Nations participants expressed a desire for inclusion, and were willing and able to engage in developing approaches to care that will better serve the needs of their communities. Inclusion meant providing opportunities to share stories and lived experiences as well as sharing strengths of community and culture. There is a need for leadership development and capacity building, particularly in relation to supporting and advocating for Indigenous health and wellness.

Negative experiences of care appear to be prevalent among Indigenous people, and without addressing this, the healthcare system will continue to fail Indigenous people. The high rates of trauma, elevated suicide risk, and past and current systemic abuses are important factors to consider when developing trauma-informed emergency departments. Healthcare professionals providing emergency healthcare need foundational education not only on Indigenous specific issues, but on patient-centred care, and compassionate communication. This is a systemic issue that should be addressed at a policy level to ensure it is consistently addressed, and overt racism towards Indigenous peoples is eradicated from emergency departments.

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Appendix A: Guidelines on Research Involving Indigenous Peoples

Leaving Participants Better Off

i. Ensure there is a benefit to participation. While the norm in research is to do no harm, RRU strives to leave participants better off as a result of participation in research. Long-term or generalized benefits to society do not, by themselves, meet this desired standard.
ii. When compensation is offered, provide compensation for time, effort, and expertise in a manner that reflects community protocols and norms and is representative of a mutual exchange relationship. Consult with community representatives before determining the nature of compensation.
iii. Consider helping build community skills and capacity by offering free workshops addressing the community's immediate learning needs.
iv. Commit to publishing and disseminating research findings in Open Access or other publicly available outlets.
v. Provide direct feedback and results to communities, organizations, and individuals involved.

Reflexivity on the Part of Researchers

i. Ensure that Non-Indigenous and Indigenous members of the research team consider their own backgrounds and positions and the ways in which these may have an effect in the course of research.
ii. Familiarize oneself with the history of research involving Indigenous peoples in general, and the communities involved in the research specifically, to understand the potential harmful consequences of research, the effects of research fatigue on an over-researched and often marginalized community and the necessity of building and maintaining trust.
iii. Understand the diversity of Indigenous peoples (for example, in Canada, individual First Nations, Inuit, and Métis, on-reserve, off-reserve, status, non-status).

Primacy of Relationships as Foundation for Research

i. Appreciate that one's particular research impacts the overarching relationship RRU has with Indigenous communities and organizations, even if the research only involves one individual or community.
ii. Appreciate that relationships precede any specific research endeavor and that they are impacted by the conduct of research.
iii. Understand that being in a relationship requires responsibility and accountability.

Indigenous Control and Respect

i. Respect community partners as nations, not stakeholder groups, with jurisdictions over research in their communities and on their traditional territories.
ii. Respect Indigenous ways of knowing and being.
iii. Familiarize oneself with and respect Indigenous methodologies and methods.
iv. In research involving First Nations, familiarize oneself with the principles of Ownership, Control, Access, and Possession (OCAP®) prior to finalizing one's research design.

Consider completing the OCAP® online course for certification. (OCAP® is a registered trademark of the First Nations Information Governance Centre (FNIGC).)

Community Engagement

i. Engage community at all stages of the research project, as appropriate, including identification of research questions, study design, implementation, interpretation of results and knowledge translation.
ii. Acknowledge and enable individuals' and communities' capacity to participate in research.
iii. Carefully assess which individuals and organizations are selected to represent Indigenous communities and on what grounds.
iv. Understand and use language appropriately to explain the researcher's approach to research methods and consultation processes and to define concepts such as community consultation, community engagement, community participation, partnerships, community review, and community control as applicable so that the communities can have clear expectations with regard to the process.
v. Learn and respect community protocols for engagement, compensation, accountability, disputes, and acknowledgments.

Indigenous Lands and Artefacts

i. Learn and respect Indigenous community protocols for conducting research, evaluation, or creative endeavours on Indigenous lands or with Indigenous artefacts.
ii. Respect Indigenous Nations' jurisdiction over research in their communities and on their traditional territories.
iii. Respect Indigenous ways of knowing and being in regard to access, handling, and control over land and artefacts.
iv. Take responsibility for any impact the conduct of research may have on the ecosystem where the research is conducted (e.g., land, water, plants).
v. Make research available to relevant Indigenous people, communities, and/or organizations.

Appendix B: Graphic Recording of Port Alberni Collaborative Planning Meeting