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Indigenous Health

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We recently finished a very successful Forum, which focused on issues related to healthy aging. Looking towards 2020, CPA will celebrate its 100th anniversary. It feels good to think that our members have been improving the health of Canadians for a century. Or have we?

The National Collaborating Centre for Aboriginal Health notes that "*Prior to European contact, Indigenous peoples of Canada had fully functional systems of health knowledge that were practiced within the contexts of their specific ways of knowing and being.*"[1] Unfortunately, that changed as the diseases and effects of colonization devastated Indigenous populations and their health systems. In the 21st century, on many health indicators, First Nations, Inuit, and Métis peoples continue to show a disproportionate burden of disease or health disparities, often rooted in health inequities.

If we plan to play a role in maintaining and improving the health of Canadians, physiotherapists in Canada will want to know the history of colonization and its effects, not just on the past health of the Indigenous people of this country, but on their quality of life today. In 2015, the Truth and Reconciliation Commission[2] (TRC) published a report called "Calls to Action," in which there are seven calls related to health care. We hope that all Canadian physiotherapists will review not only the Calls to Action, but the TRC report as well, to begin to grasp the extent of the impact of colonization on all Indigenous peoples. This issue of PT Practice starts the process.

The 18th Call to Action asks all levels of Canadian government to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties. As physiotherapists and a stakeholder in Canada's health care system, it is our duty to act on this call. Many of you are thinking, "*What can I do about that? It's a big problem.*" I don't have an easy answer, but in this issue of Physiotherapy Practice, Lacey Nairn Pederson (Saskatchewan) starts the conversation with an article offering ideas on what physiotherapists can do at a local level to work towards meeting the TRC Calls to Action, while reflecting on some of her work with Indigenous communities.

The 22nd Call to Action[2] is for "those who can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients." Amber Skye (Ontario) shares her insight into harmonization of Traditional and Western approaches to health and wellness, concepts of decolonization, and cultural safety in health care, while Allana Beavis (Manitoba) reflects on her work with First Nations' communities in Manitoba.

The 23rd and 24th Calls to Action ask that there be an increase in the number of aboriginal professionals working in health care and for all schools training health professionals in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism. Simone Gruenig and Robin Roots (British Columbia), Moni Fricke (Manitoba), Lisa Jasper (Alberta), and Sarah Oosman and Peggy Proctor (Saskatchewan) review the four western provinces' Indigenous admissions and curriculum.

Cultural humility is found in the First Nation's Health Authority, which CPA is acting upon for its members and staff. At our recent Forum held in PEI, a session was held for all CPA Board members, the leaders of our component groups and staff, to improve our awareness of how colonization devastated the health and lives of Indigenous peoples and, also, how there continues to be much work to be done to even begin to understand and address those negative effects.

CPA acknowledges the inequities that have been imposed by colonization on this country's original peoples. We also recognise that if we are to be leaders in the delivery of health services and promotion of equity in health, we must understand the history of colonization and its impact on the health of Indigenous peoples today.

Viivi Riis, PT
President, Canadian Physiotherapy Association
@ViiviRiis

1. https://www.ccnsa-nccah.ca/docs/context/FS-OverviewAbororiginalHealth-EN.pdf
2. Truth and Reconciliation Commission of Canada: Calls to Action. 2015

Canadian Physiotherapy Association

Managing Editor
Victoria Zielinski

Art Direction
Shift 180

Contributors
Lisa Arcobelli
Isabelle Barreira
Jessica Barudin
Allana Beavis
BMS Group Inc.
Pat Camp
Priscilla Flett
Amanda Fortin
Moni Fricke
Simone Gruenig
Lisa Jasper
Stacey Lovo Grona
Marilyn Neufeld
Kate O'Connor
Jennifer O'Neil
Sarah Oosman
Lacey Nairn Pederson
Peggy Proctor
Viivi Riis
Robin Roots
Amber Skye
Margret Thomas
Bonnie Tinker
Hiba Zafran

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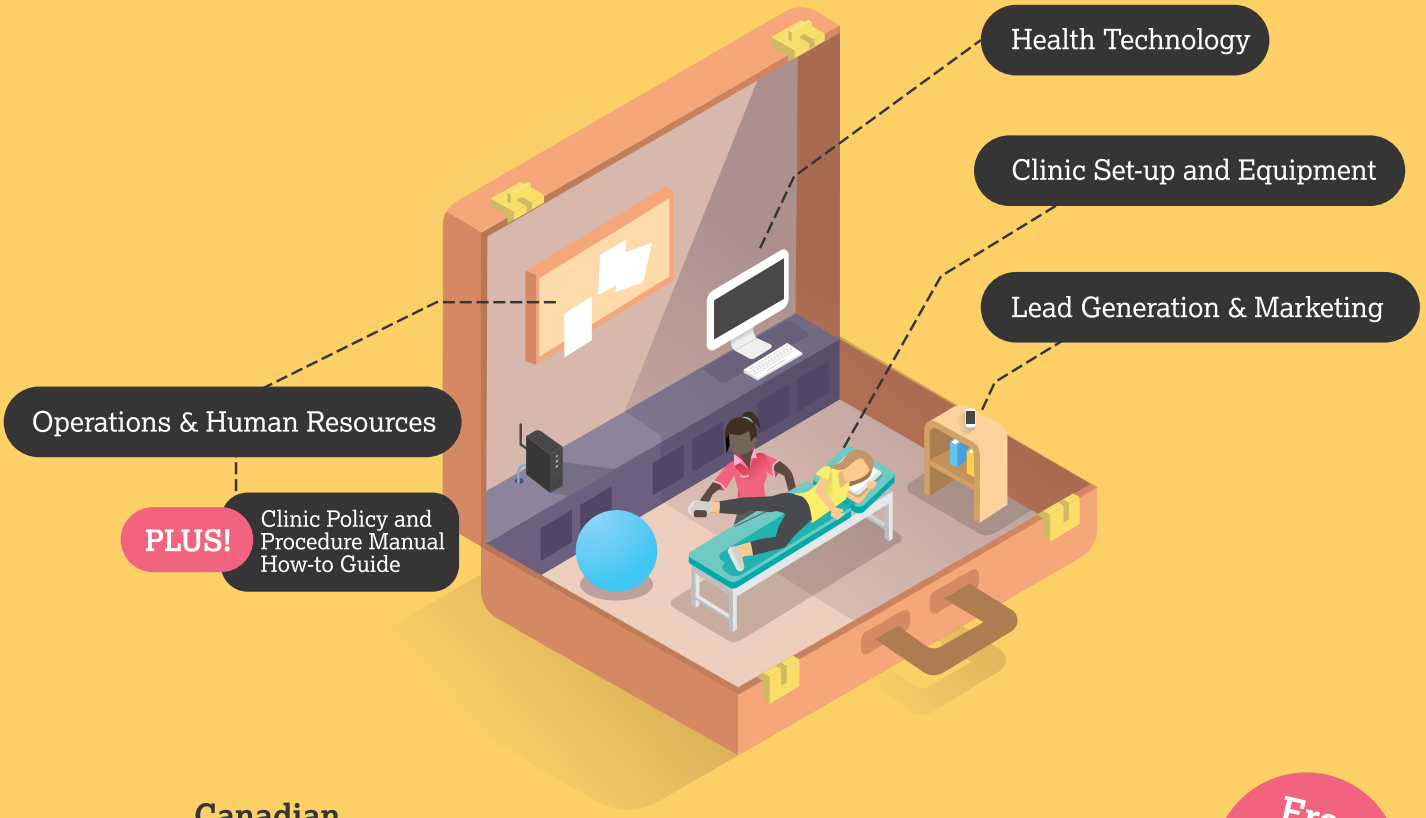

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Amanda Fortin receiving the Saskatchewan Physiotherapy Association New Member Contribution Award, May 2019. Sarah Oosman and Peggy Proctor presented the award.

I had mixed emotions, driving further out of the city, out of my comfort zone, and deeper into rural Saskatchewan for my first clinical placement as a physiotherapy student. As someone who has spent the entirety of my life living in urban settings, the trek to the unknown was unnerving.

I finally arrived; as I walked through the front doors, I was greeted with a series of "*you must be new around here*" and "*welcome, it's great to have you*." I knew immediately that I was in for a wonderful experience and that I already felt as though I belonged in this community.

After being given a tour of All Nations' Healing Hospital in Fort Qu'Appelle, Saskatchewan, located on Treaty 4 Territory, I had to double check with my instructor that we were actually at a hospital. The hospital, which serves a large number of individuals who are Indigenous, strives to treat the whole person by combining traditional and Western medicine through cultural programming, mental health services, health education, and having a complement of health care providers all under one roof.

Over the course of my month in rural Saskatchewan, I was not only able to apply my newly learned skills to clinical scenarios, but I was also able to see the bigger role that building community and human relationships have in the role of healing. I was in awe of the resiliency and kinship that I witnessed each day and that traditional and Western medicine can co-exist with positive results.

My name is Amanda Fortin and I am a physiotherapist working in acute care in the Saskatchewan Health Authority. I am proudly writing this from Treaty 6 Territory and the Homeland of the Métis. I chair the CPA Global Health Division's Indigenous Health Sub-Committee. The CPA Indigenous Health Sub-Committee was formed in 2015 as a means of mobilizing action and providing leadership within our profession on the topic of Indigenous health. We have developed and curated resources to assist practitioners on the CPA Global Health Division's website.[1]

We know that colonization of Canada has negatively impacted all aspects of health of Indigenous peoples in Canada. Significant health disparities exist between Indigenous and non-Indigenous Canadians, such as increased rates of mental illness, diabetes mellitus, and obesity for a number of reasons including historical oppression, ongoing discrimination, policy, and access to care.[2,3]

The Truth and Reconciliation Commission (TRC) released a report in 2015 that highlighted the need for all Canadians to engage in the process of Reconciliation. Of the 94 Calls, seven are specific to health and should be examined by all Canadians and Canadian organizations to reflect on how we might engage in this process.[4]

As a profession, we have a duty to be advocates for health policy changes as a means of contributing to the Reconciliation process. As individuals, some actions that we can each do are reading and being familiar with the TRC report, using a trauma-informed approach to care, practicing reflexivity, appreciating the determinants of health that impact our clients, and incorporating shared decision making with our clients. This issue of Physiotherapy Practice is sure to interest readers both professionally and personally. It will allow you to see the current state of Indigenous health in Canada and appreciate the opportunities for improvement. It has been a privilege to be able to connect with the contributors of this issue and to learn more about the incredible work and projects that they are involved with across Canada.

If you are interested in learning more about the CPA Indigenous Health Sub-Committee, I can be reached at GHIndigenous@gmail.com.

Amanda Fortin, MPT
Indigenous Health Sub-Committee Chair, Canadian Physiotherapy Association, Guest Editor

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Working as a Physio "Up North"

Isabelle Barreira, PT

After finishing my equivalency degree at McGill University in Fall 2018, I was fortunate to begin working as a permanent physiotherapist for the Cree Board of Health and Social Services of James Bay, in the Cree community of Mistissini.

During my stage at the Children's Hospital, I encountered a few patients coming from "Up North" communities, both Cree and Inuit. Until that moment, I was unaware of their health systems and their availability of services. I was intrigued, so I began researching about life in Northern Quebec and the available opportunities for health care professionals. The more I researcherd, the more I wanted to embark on a new adventure.

With the application process completed, I was ready to go and by the end of October, I was leaving Montreal to live one of the most enriching experiences of my life. At that moment, I had mixed feelings of excitement, fear, and uncertainty.

Upon my arrival in Mistissini, my local coordinator and another physiotherapist, who was working part-time, temporarily, in the community, welcomed me. On the same day, I had a tour of the clinic and the Multi-Day Service Center, where I would be providing physical therapy services. The staff was very excited to have me on board, and they were very welcoming.

As the months passed, I fell in love with the community, the quietness, the nature, the slow-paced environment, and other entertainment activities. The community includes a big sports complex with a gym and a pool, where many activities are being offered, from Zumba to boot camp classes. Throughout the winter, there are hockey and broomball tournaments as well.

The physiotherapy department of Mistissini has never had a permanent physiotherapist, so my main role was to organize the department and manage an extensive waiting list of days to years. The rates of chronic diseases are high amongst the Cree communities, which increases the demand for rehabilitation services. Most patients presented with osteoarthritis, tendinopathy of the rotator cuff, and chronic lower back pain.

Working here has been an incredible experience, professionally and personally. I am grateful to have chosen to work "Up North" as my first job as a physiotherapist. It is very rewarding to have such a positive impact in people's lives, as well as having a recognition from other professionals of the importance of your role. I believe that all the experience that I have been acquiring in this amazing place allows me to be a better physiotherapist for my clients and colleagues.

The rehabilitation team serve all nine Cree communities in Quebec. Each community has its own physiotherapy position, and some professionals, such as speech language pathologists, serve one or more communities. There is always a need for physiotherapists: either for temporary or permanent positions. For more information regarding the application process, please visit our website at www.creehealth.org.

About Isabelle

Isabelle Barreira holds an Equivalency Degree in Physical Therapy from McGill University. She is originally from Brazil, where she obtained her PT degree. Before validating her studies, Isabelle was granted a full-time scholarship at Concordia University, founded by the National Council for Scientific and Technological Development – (CNPq) in Brazil. In Brazil, Isabelle had the opportunity to participate in different research projects with a cardiac population. Clinically, she enjoys working in an outpatient setting and has developed an expertise within the orthopaedic clientele. Since 2018, Isabelle has been working full time for the Cree Board of Health and Social Services of James Bay in Mistissini, QC.

Jordan's Principle and the Inuit Child First Initiative:

Supporting Access to Physiotherapy for First Nations and Inuit Children

Kate O'Connor, Senior Policy Analyst, Jordan's Principle, First Nations Inuit Health Branch, Indigenous Services Canada

There are several barriers to receiving care in remote, northern, and on-reserve communities, but understanding how the system works (or doesn't) is a big part of life for First Nations and Inuit peoples. While health care is a responsibility of provincial and territorial governments, the federal Non-Insured Health Benefits Program provides essential health services to registered First Nations and Inuit peoples. However, for individuals with a disability or complex needs, such as a child with cerebral palsy, the Non-Insured Health Benefits program highlights the gaps in the system and the challenges to supporting a child as they grow. This is because the federal Program provides access to medical transportation to travel to urban centres for care, and medical equipment and supplies, such as a wheelchair, walker or orthosis, but not a ramp into the child's home or physiotherapy to support the child by improving strength, mobility, and independence. The result is a ripple effect, starting with the quality of life of the child, the well-being of the family who care for the child, the friends and the community who try to support the family, and amplified by the fact that there are many other children and families experiencing limited resources to help children achieve their full potential.

Health professionals who work with First Nations and Inuit children, families, and communities are experts in the complex intersections of Canadian health systems and see the flaws in the system. These professionals often play the role of advocate and navigator, in addition to providing care and compassion.

Jordan's Principle

Jordan River Anderson was a boy from Norway House First Nation in Manitoba, born in 1999 with multiple disabilities and stayed in the hospital from birth. When he was two years old, doctors said he could move to a special home for his medical needs. However, the federal and provincial governments could not agree on who should pay for his home-based care. Jordan remained in the hospital until he passed away, at the age of five.

In 2007, the House of Commons passed Jordan's Principle in memory of Jordan. It was a commitment that First Nations children would get the products, services, and support they need, when they need them. Payments would be worked out later. However, in 2007, the First Nations Child and Family Caring Society (Caring Society) and the Assembly of First Nations (AFN) submitted a complaint to the Canadian Human Rights Tribunal (CHRT) regarding the underfunding of First Nations child and family services by the Government of Canada and the narrow application of Jordan's Principle.

In January 2016, the complaint by the Caring Society and the AFN was substantiated by the CHRT and the Government of Canada was ordered to:

- cease its discriminatory practices;
- reform the federal First Nations Child and Family Services Program;
- cease applying its narrow definition of Jordan's Principle (limited to children with multiple health conditions involving several providers); and
- take measures to immediately implement the full meaning and scope of the Principle.

The Tribunal has issued subsequent orders regarding how Jordan's Principle should be defined and implemented. In fact, in 2017 the CHRT ruled that when a government-funded service is not necessarily available to all other children or is beyond the normative standard of care, the government department of first contact will evaluate the individual needs of the child to: ensure substantive equality; culturally appropriate services; and/or to safeguard the best interests of the child.

Improving Access to Rehabilitation for First Nations

With limited access to physiotherapy and other health professional services, families and communities can secure federal funding under Jordan's Principle and the Inuit Child First Initiative to address children's unmet needs. This is where professionals, such as physiotherapists, need to promote access to care, not only by providing services, but informing families and communities that funding is available. Through Jordan's Principle and the Inuit Child First Initiative, First Nations and Inuit families can access funding for rehabilitation, and communities can apply for funding to manage, coordinate, and deliver care in communities, recreation centres or schools, based on the needs of children.

Since 2016, over 275,000 individual and group requests have been funded through Jordan's Principle. Examples of services and products that Jordan's Principle covers include physiotherapy, speech language pathology, occupational therapy, respite care, mental health support, educational support, adaptive and sensory equipment, mobility

aids, and other medical services. For children who previously did not have access to rehabilitation and care for complex disabilities and mobility challenges, Jordan's Principle and the Inuit Child First Initiative can help.

Keewatin Tribal Council Resolution To Support Jordan's Principle

On October 16, 2018, the Keewatin Tribal Council issued a resolution at their 39th Annual General Assembly supporting Jordan's Principle and identifying how First Nations children now have access to rehabilitation in eleven reserves in Northern Manitoba. With a total of approximately 10,000 residents, these communities are isolated, with limited access to health professionals, beyond nurses and physicians. The challenges for children and youth with complex needs are amplified by the fact that the federal government's Non-Insured Health Benefits program is limited to medical supplies and equipment, leaving many necessary rehabilitation services unavailable to First Nations. Jordan's Principle has sought to change this. In July 2017, a community program was funded under Jordan's Principle, establishing relationships between communities and service providers and bringing in physiotherapy, occupational therapy, and speech and language pathology through the Rehabilitation Centre for Children. This is one example of many where Jordan's Principle is filling a gap in access to care, but also striving to achieve health equity by providing supports and services to First Nations children.

Conclusion

In 2017, the federal government issued a mandate to the new Minister of Indigenous Services to "lead work to create systemic change in how the federal government delivers health services to Indigenous peoples." This mandate includes identifying service delivery models that are patient-centred, focused on community wellness, and considers the link between health care and the social determinants of health. This is a tall order, and one that Jordan's Principle and the Inuit Child First Initiative are seeking to implement. However, it cannot be done without the experience of professionals, like physiotherapists, who have built strong relationships with patients and communities to deliver culturally sensitive care. Budget 2019 announced $1.2 billion over three years for the continuation of Jordan's Principle and $220 million over five years for the Inuit Child First Initiative. This commitment responds to the unmet needs of First Nations and Inuit children, no matter where they live in Canada. But systemic change requires sharing knowledge of the models of care that work. This is how #physiocanhelp.

To learn more about Jordan's Principle and the Inuit Child First Initiative, or to make a request go to:
https://www.canada.ca/en/indigenous-services-canada/services/jordans-principle.html
or
https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/supporting-inuit-children.html
or
Jordan's Principle Call Centre: 1-855-JP-CHILD (1-855-572-4453), open 24 hours a day, 7 days a week.

Jordan's Principle and the Inuit Child First Initiative have regional representatives across Canada, as well as local service coordinators in First Nations communities or organizations across Canada. Please contact the local Jordan's Principle representative to get this information.

About Kate:

Kate O'Connor is a Senior Policy Analyst with Indigenous Services Canada, where she contributes to a new vision for community-led programs and services, and promotes access to health, social, and education supports and services to First Nations and Inuit children. Before working for Indigenous Services Canada, Kate worked as the Director of Practice and Policy for the Canadian Physiotherapy Association and her heart remains with the profession. Kate is proud to continue to advocate for access to physiotherapy to promote health and wellbeing for Indigenous peoples.

Building Partnerships in Indigenous Wellness

Lisa Arcobelli, PT, School of Physical and Occupational Therapy, McGill University, CPA Member since 2003
Priscilla Flett, PT, Manitoba First Nations Education Resource Centre, CPA Member since 2016
Moni Fricke, PT, College of Rehabilitation Sciences, Rady Faculty of Health Sciences, University of Manitoba, CPA Member since 2001
Sarah Oosman, PT, School of Rehabilitation Science, University of Saskatchewan, CPA Member since 1998
Stacey Lovo Grona, PT, School of Rehabilitation Science, University of Saskatchewan, CPA Member since 1995; and
Amanda Fortin, PT, Saskatchewan Health Authority, CPA Member since 2013

Readers may recall in the September/October (2018) issue of Physiotherapy Practice, an "Invitation to Join on the Effort to Reduce Indigenous-Settler Inequities." This past article shared our committee's three goals for 2018-2020 and invited our physiotherapy colleagues from across the nation to join us in reducing Indigenous-settler inequities and collectively meet our goals.

As we continue our work with Indigenous colleagues and actively engage with Indigenous communities, we thought it might be interesting and helpful to celebrate and showcase exemplars of solidarity and authentic partnerships across Canada. Some of the stories we share are newly developing, while others have been forming over years of relationship building and respectful engagement. Here is a sampling of stories of partnerships supporting Indigenous Wellness from our physiotherapy colleagues across Canada.

A Physiotherapist's Experience in Cree Communities in Quebec - *Lisa Arcobelli*

Eeyou Istchee is the traditional name of the First Nation Cree Territory of James Bay in Quebec, covering an area approximately the size of France and home to nine vibrant Cree communities. Eeyou Istchee's population is about 18,000, 95% of which are Cree. For several years, I have had the privilege of working as a PT in Chisasibi and Whapmagoostui, which are two of these communities. Each community has a Cree rehabilitation assistant, called a Rehabilitation Monitor (RM), who works together with therapists as a language and cultural interpreter. Collaborating with RMs and other Cree colleagues for patient care and program development has been one of the most rewarding and enriching aspects of my work in Eeyou Istchee. Along with my patients, they have helped me develop greater patience and humility, better understanding in the subtleties of non-verbal communication, and learn the importance of building relationships and co-creating safe spaces that foster trust.

Manitoba First Nation Education Resource Centre (MFNERC) - *Priscilla Flett*

My name is Priscilla Flett and I'm a First Nation member of the York Factory First Nation, born and raised in Churchill, Manitoba. I am a new grad working with MFNERC, which provides the province's education, administration, technology, langauge, and culture services to First Nations' schools in Manitoba. We provide clinical services, such as physiotherapy, occupational therapy, speech language pathology, assistance for those deaf and hard of hearing, and psychology to 56 on-reserve schools, funding made recently available through Jordan's Principle. We have four physiotherapists on staff serving approximately 40 schools within the province. We provide services to children aged 4 - 21 years in their school setting. Our main objective is to ensure that all students are able to partake in their educational environment to the best of their ability. We also train educational assistants (EAs) regarding gross motor programming, lifts and transfers, and adapted equipment. This year, in collaboration with the occupational therapists, we are setting up sensory motor rooms in every school and setting up workout equipment that includes a squat rack, bench press, weights, and kettle bells in every high school.

U of M MPT Students Engaging in the Calls to Action - *Moni Fricke*

In the realm of education, physiotherapy students at the University of Manitoba have had the opportunity to engage themselves in the TRC Calls to Action in several ways. This year, an existing simulation learning activity, focusing on difficult conversations, intro-

duced a new scenario in which students were required to address microaggressions in racism. Interacting with a trained actor playing the role of a senior colleague who makes uninformed racist generalizations about their patient population, learners were required to break stereotypes in order to provide safe quality patient-centred care. Outside the classroom setting, physiotherapy students are given the opportunity, alongside students from eight other health professional programs, to immerse themselves in an interprofessional placement in a rural and/or remote First Nation community. The Rady Faculty of Health Sciences has partnered with several First Nation communities building on existing relationships to provide the learners with the opportunity to examine and challenge personal and institutional biases, stereotypes, and beliefs in order to move towards providing more culturally safe care.

Designing & Implementing an Online Indigenous Wellness Course for Health Care Professionals, Guided & Directed by Indigenous Community Members, Scholars & Organizations - *Sarah Oosman and Stacey Lovo Grona*

In Saskatchewan, physical therapists Stacey Lovo Grona and Sarah Oosman are part of a team from Continuing Medical Education (CME) and Continuing Physical Therapy Education (CPTE) who have partnered with Indigenous community members, Elders, Knowledge Keepers, researchers, and health providers to design and implement "The Role of Practitioners in Indigenous Wellness" online course. This course is grounded in Indigenous worldview, instructed by Indigenous colleagues and partners, and delivered in partnership with CPTE and CME at the University of Saskatchewan. Our team engages with Indigenous community members and organizations on an ongoing basis to ensure learning objectives are updated in culturally relevant ways. In keeping with oral tradition, this course is delivered through the voices and stories of leaders in Indigenous health care. Registrants are taken on a journey of personal reflection while exploring the health and wellness experiences of Indigenous peoples – both past and present – at an individual and community level. The course encourages interactive discussion and private self-reflection that is guided by Indigenous facilitators.

First Nations and Métis Health Service, Saskatchewan Health Authority - *Amanda Fortin*

The Saskatoon Health Region created a First Nations and Métis Health Service through building partnerships with local First Nation and Métis communities, with an overall goal of ensuring that the four guiding spirits of mental, physical, emotional, and spiritual health are being respected in care. This service assists patients and their families in several ways, such as navigating the system, connecting with Elders, and assisting with interpretation. They assist health care professionals and staff with education, including building cultural safety and awareness, and serve as a resource. There are regularly scheduled traditional ceremonies in hospitals, such as smudging, open to all individuals who wish to join. As a physical therapist, I can work with the First Nations and Métis Health Services in ways that have been invaluable to my development as a health care provider. I am honoured to work for an organization that has prioritized improving the health outcomes and care experiences for Indigenous People.

Our hope, by sharing these stories, is that it will stimulate other physiotherapists to continue engaging in community-driven, culture-based activities and partnerships, to support reconciliation and positive change. For those physiotherapists who are already engaged in such activities, we want to hear from you! If you have a story to share please contact the Indigenous Health Sub-Committee Chair, Amanda Fortin (ghdindigenous@gmail.com). Sharing and learning from one another is an important step to collectively reducing Indigenous-settler inequities in our communities, provinces, territories, and nation.

Decolonizing Health Care:

Addressing Gaps in Health Care for Indigenous Communities

Amber Skye, MPH

What is Decolonization?

This is a big question. Decolonization has been a buzz word in the world of academia for some time since the release of Linda Tuhiwai Smith's landmark book *Decolonizing Methodologies: Research and Indigenous Peoples* in 1999. Smith's work is now a major work in Indigenous research and academia as it is one of the first to comprehensively address the inherent colonial process involved in research, while also articulating decolonizing Indigenous methodologies. However, decolonization has only more recently become discussed and advocated in the front lines of health care for Indigenous people. I find it to be a very misunderstood word because it is more than a concept - it is a process, and that process is a very difficult one for many people to grasp conceptually and practically.

Decolonization requires the acceptance that we (Indigenous and non-Indigenous people alike) have been educated and trained to practice from a place of colonial thought, all of which does not provide the space for Indigenous knowledge and ways of doing. As an example, if you thought about every book you have read and asked yourself, "Was any Indigenous voice or experience expressed?" That exercise alone is telling of the place from which we are learning about the world. Absence in the education system has created the misconception that Indigenous people do not have a knowledge system, or at least not one that is relevant today. Indigenous people are represented as "frozen in time," merely a part of history (Battiste, 2005). This is all despite the fact that Indigenous people have a vast amount of knowledge and have contributed to the world significantly. Indigenous knowledge has been made invisible through the classification and trivialization of non-European science and technological innovations, and invention as "art" (Ascher, 1991). Battiste (2005) refers to this as cognitive imperialism because it "denies people their language and cultural integrity by maintaining the legitimacy of only one language, one culture, and one frame of reference." Not to mention that Indigenous languages, cultures, and practices (the expression of Indigenous thought) were systematically targeted through colonial policy (see: Indian Act 1876) and practice (e.g. Residential School System).

As a result, many Indigenous people themselves have forgotten Indigenous knowledge systems, but more often Indigenous knowledge is simply overlooked in modern contexts. However, Indigenous communities are increasingly engaging in a process of cultural reclamation as a tool to heal from the trauma and impacts of colonization. Cultural reclamation began markedly in 1990's after the Oka crisis brought a high level of attention to Indigenous politics and the ongoing oppression and marginalization of Indigenous people in Canada and throughout North America. At the same time, it increased attention to Indigenous education and the need for Indigenous control over our education systems and continued assimilation through lack of Indigenous representation, voice, and knowledge in education. In the coming years, Indigenous communities would go on to develop Indigenous language immersion schools that focus on Indigenous language and culture. While these schools have produced many Indigenous language speakers and aided in the process of cultural reclamation, Indigenous thought and voice is still absent in the mainstream education system and for Indigenous youth who do not attend immersion schools. Consequently, most Indigenous youth and Canadians alike have little to no access to Indigenous knowledge and language.

How, then, do we begin to find the space for Indigenous thought and practice in health care? With an education system that marginalizes Indigenous thought, it becomes essential to engage in the process of decolonization. Decolonization is a strategy of empowerment that rejects colonial constructed narratives of Indigenous people, of education, of governance, and of health and wellness. Essentially, it challenges the uncritically accepted ideologies of the dominant culture (Anderson, 2000). Indigenous scholar Michael Yellowbird explains decolonization as ``the intelligent, calculated, and active resistance to the forces of colonialism that perpetuate the subjugation and/or exploitation of our minds, bodies, and lands, and it is engaged for the ultimate purpose of overturning the colonization structure and realizing Indigenous liberation" (2008). With this definition in mind, how do we begin to decolonize our health care systems?

As an Indigenous woman, I see this decolonization being essential to addressing the gaps in the current health care system. As you may be aware, Indigenous people suffer from unarguably the worst health status in the country. On almost every measure of health, we fare much worse than the general population. Given this state of un-wellness, we must ask ourselves, as practitioners, "What is wrong with the system? How are we failing so many people?" These are questions I ask myself frequently as a process of critical reflection. Reflection is an essential step in the decolonization process. Indeed, decolonization must first happen in our

Pat Hess, Traditional Medicine Helper, Six Nations Health Services, and Cameron Hill, Cultural Advisor, Six Nations Health Services, harvesting Haudenosaunee medicines for the community.

"Many contemporary problems faced by Indigenous people can be traced to the clash of Indigenous and Western worldviews that challenge Indigenous existence."

minds. We must change the way we have uncritically accepted ideologies of dominant culture to begin to create the space for Indigenous thought to be realized. Through reflection, we can begin to challenge our thinking about health, wellness, and how we address these in practice. As a young Haudenosaunee woman heading off to University, the advice I was given by my grandparents was to never forget who I am and to only take what would help my people and leave the rest. This is how I began my decolonization work, critically reflecting on what I was learning about health in university and asking myself if this is what my people (the Haudenosaunee) would have done. Does it fit with a Haudenosaunee worldview of health and wellness? Many times, Western theories did not. However, I understood that the Haudenosaunee had their own models of health and wellness that could be utilized. This is another critical piece to decolonization; understanding the importance and application of Indigenous knowledge - Indigenous ways of knowing and doing.

Why is Decolonization in Health Care Necessary?

Many contemporary problems faced by Indigenous people can be traced to the clash of Indigenous and Western worldviews that challenge Indigenous existence (Littlebear, 2000). When we fail to acknowledge Indigenous ways of knowing and doing, we deny Indigenous people access to their identity. This is a form of epistemological violence; we are telling Indigenous people (often unknowingly) that their way of thinking, knowing, and doing are not important or valid. For frontline practitioners to disrupt this practice in health care, it requires acknowledging that what we have learned might not be the best approach or `best practice` for working with Indigenous communities and populations. In fact, sometimes our `best practice` might be harmful if we are perpetuating knowledge and practices based on colonial ideologies that conflict with Indigenous ways of knowing and doing. This is no easy task in the health care system that adheres to stringent `best practices` or clinical guidelines, but we have to be aware of the roots of the systems we work within. How much of any clinical practice guidelines have been developed with an Indigenous voice? In more instances than not, there has been little effort to have any Indigenous representation in research that informs clinical practice guidelines. As health care providers, we have to acknowledge this and challenge how we provide care, and what voice and knowledge we are privileging in the process.

At Six Nations Health Services, we have been working diligently to think critically about the care we provide, including holistic health care needs, to the community. Specifically, we have started to train our health care providers to be able to provide care that is founded in Haudenosaunee knowledge, and supports our local knowledge of health and wellness through decolonization training and educational initiatives for our staff and community. This training provides the knowledge and space to guide our staff through critically reflecting on how we design and deliver health care in the community. This often involves challenging the ways things have been done and the way policies have been designed. This process hasn't come without its challenges, but we are making strides in addressing longstanding gaps in health that haven't always met the holistic needs of our community. Decolonization is an ongoing process that requires continual reflection and challenging the dominance of western thought, but we are confident that this process is key to addressing the health care needs of our community.

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The Art of Being a Fly-In Physiotherapist in Northern Manitoba: Perspectives from PTs at Community Therapy Services

Allana Beavis, PT, BHSc, MSc, MScPT, CPA Member since 2012; **Margret Thomas**, PT, DipPT, BPT; **Marilyn Neufeld**, PT, BMRPT

The Northern Outreach Program through Community Therapy Services (CTS) employs physiotherapists who travel to remote sites in northern Manitoba.[1] The 10 First Nations communities that it serves include Bloodvein, Little Grand Rapids, Pauingassi, St. Theresa Point, Wasagamack, Garden Hill, Red Sucker Lake, Norway House, Berens River, and Poplar River. Most of these communities are fly-in access only, except for the ice roads in the winter. Here, we offer our reflections on our practice as fly-in physiotherapists servicing northern Manitoba.

You Need to be Adaptable

The first lesson is this: things will not necessarily go as planned. You could show up at the airport an hour before your early morning flight, only to have it cancelled hours later due to weather conditions. You could board the plane, but not be able to land in the community you are travelling to. Some airports near First Nations communities are located on islands and the fog coming off the lake can obscure the pilot's ability to see the tarmac. You might need to "hitch" a ride on the winter road when air travel is not possible. You could land in the community to discover that the power is out at the Nursing Station. A myriad of challenges may present themselves during a fly-in trip, but these scenarios are simultaneously what make almost every trip an adventure. In order to do this kind of work, you must have a good sense of humour and be ready to adapt to whatever circumstances you encounter.

There are "comfort tricks" that make a travelling PT's life easier. Make sure you have seasonally appropriate and safe clothing, and check the local weather before travelling. The roads and environment can be rugged, so investing in a pair of hiking shoes is indispensable. Plan your meals in advance and pack a cooler. Always bring extra food and clothes in case of an extended storm stay. Keep extra food in your carry-on in case your cooler flies to another community. Bring a good book and download episodes on Netflix in advance.

You Need to be an Advocate

The inequity with respect to access to physiotherapy services for Indigenous peoples, especially those residing in remote areas of Canada, is well documented.[2,3,4] As fly-in PTs, we face the reality of this inequity head on. In several of the First Nations communities we serve, we are the only PTs providing local services to adults. Before Jordan's Principle[5] came into effect in 2017, we were also providing the majority of community-based physiotherapy services to paediatric clients. Now, children in need of locally provided physiotherapy services are primarily seen by centres and organizations that receive funding through Jordan's Principle. In the wake of system reorganization within the Winnipeg Regional Health Authority, there are fewer opportunities to refer clients to Winnipeg to access more intensive physiotherapy when needed. These conditions are further complicated by the fact that private physiotherapy clinics are not accessible for people living in the communities that we serve for a variety of reasons. Health Canada's Non-Insured Health Benefits (NIHB) Program does not fund private physiotherapy services.

We see the sequelae of this access disparity in our practice. It is not uncommon for a client to present with decades-long chronic back pain that would have been amenable to early physiotherapy intervention. Similarly, a client may have remotely sustained a fractured or have undergone surgery, but did not achieve the best possible outcome given the lack of timely physiotherapy intervention.

The disproportionate burden of disease and disability experienced by Indigenous peoples, coupled with limited access to physiotherapy services,[4] requires that advocacy feature heavily in our clinical practice. A good understanding of the health care system is necessary in order to help our clients access the best opportunity to rehabilitate. We collaborate frequently with other health care disciplines and community health representatives. Joint consultations with nurses and/or doctors in Nursing Stations are a common occurrence. We often write letters to Band Councils to request modifications for housing and send letters of justification to NIHB for equipment. Our role as advocates also extends to appreciating the value and importance of the community-based physiotherapy services that we provide in First Nations communities. Our agency is involved in an ongoing manner in justifying the provision of services to persons in their home communities when possible and appropriate, on the basis of not only increased comfort and convenience to the patient, family, and community, but improved adherence to treatment as well.

You Need to go Beyond Advocacy; You Need to be an Ally

Maybe you find yourself now asking, "How did these disparities with respect to access to physiotherapy and other health care services manifest?" This line of questioning is one of the first steps toward allyship, which is an ongoing process of learning about how racism permeates

Crossing the lake from the airport on Stevenson's Island to Garden Hill.

Charter flight to and dock at St. Theresa Point.

Sunset view over a bay from behind the hospital in Norway House.

Canadian society and its institutions, and acting to disrupt systemic oppression.[6]

Allyship is fundamental to providing physiotherapy services to residents in remote First Nations communities. It is important to understand how colonization has, and continues to, create health inequities that negatively impact Indigenous peoples. The history of colonization in Canada is that of attempted "cultural genocide." It involved, but was not limited to, the dispossession of Indigenous peoples from their lands and relocation to reservations, forcible removal of children from families and their placement in residential schools in order to sever familial and cultural ties, disruption of existing forms of government, and prohibition of traditional healing practices. The consequence is that Indigenous peoples have endured significant trauma and experience reduced opportunities to live healthy lives. The reports created by the Truth and Reconciliation Commission (TRC) are important resources in terms of understanding our shared history in Canada and contain Calls to Action relevant to physiotherapy.[7,8]

Allyship also involves the realization that colonization has a strong foothold within our profession. Therefore, there is the potential of unintentionally perpetuating colonization through our practices and harming clients who are Indigenous.[9] Another element of allyship in this context is engaging in continuous reflection and deconstructing our clinical practice in order to serve Indigenous clients better. PTs in the Northern Outreach program have provided practicum placements to physiotherapy students, a part of which is informing students of this history, the disadvantages experienced by Indigenous peoples, and how this affects our practice.

What we are also hinting at here is the importance of practising cultural safety. We won't dive deeply into how to provide culturally safe physiotherapy services to Indigenous peoples. There are insightful articles published in previous editions of Physiotherapy Practice that offer a launching point into this particular learning journey.[10,11] There are also exceptional online courses that offer cultural safety training.[12] Having knowledge regarding trauma-informed care can promote safety, trust, healing, and collaboration when working with Indigenous peoples.[13]

We also want to emphasize that despite all the barriers, challenges, and historical and current trauma that influence the health and lives of Indigenous peoples, there is incredible resiliency within Indigenous communities.

You Need to Build Relationships

The moment you arrive at the airport, you are visible as a health care provider to members of the community that you are traveling to. It is likely that your colleagues and some of your clients will be on the same flight. The stage is set well in advance of the clinical interaction. Simultaneously, there is a long history of Indigenous peoples having negative experiences with the health care system and a possible distrust of institutions to contend with. When we consider how to move forward in a spirit of reconciliation, it is important to begin building trust from the first moment.

When your feet hit the ground in the community, you are on their land. The gravity of this is that you have to pay attention to your own identity, especially if you are of European settler descent, and the historical role that land has played in settler and Indigenous relations.

It is important for you to become aware of local assumptions and beliefs about good manners and appropriate behaviours, and whether these vary with age and gender. You especially need to learn what is considered courteous conversational behaviour. Humour is a powerful tool and very helpful in developing rapport.

You may find, that at first, many referrals are from people working at the Nursing Station and then their family members. Over time, you see more self-referrals as the community becomes more familiar with you as a person and with growing recognition of what you can offer as a PT.

You Need to Adjust Your Clinical Practice

You are working in a Nursing Station, which means you do not have a lot of traditional physiotherapy tools at your disposal. The clinic rooms are equipped with medical examination beds and, for many clients, it is not safe for them to transfer onto this surface. You'll have to assess hip ROM for an 80-year-old grandmother another way. Or maybe you have to teach someone active-assisted ROM post-op rotator cuff surgery, but there are no sticks to use. The long piece of crown moulding in the back storage room will have to do. Your interventions and methods of teaching exercises become creative very quickly.

Being that our services are based in the Nursing Stations, we are unable to do home visits. There are no community-based OTs servicing adults. This means we are often involved in medical equipment prescription. The challenges to providing the most appropriate equipment include needing to base clinical decisions off descriptions and photographs of the home environment, shipping costs, and being unable to trial equipment.

Many clients who present for physiotherapy appointments were referred, rather than initiating services themselves. An overview of the profession and what can be offered lays the groundwork for a dialogue. The referral might say "exercises for right knee osteoarthritis," but asking the client what the problem is from their perspective is immensely helpful. This discussion shifts the power balance in the clinical interaction from the clinician to the client and the problem can then be solved together.

All too often, we, as PTs, enter the clinical interaction with our western biomedical culture. We cannot assume, especially in this practise context, that clients are going to appreciate our frame of reference. Instead, we must contextualize their care in their world, or in other words, meet them where they are at. This involves a sincere curiosity and asking questions about their day-to-day lives. Other clinicians may not have taken the time to explain diagnoses to their clients. Taking the time to go over the anatomy and condition is always valuable.

Aerial view of Red Sucker Lake from a Perimeter Airlines flight.

You'll Have an Incredible Experience

Being a fly-in PT exposes you to a vast array of conditions and clinical situations, and provides the opportunity to acquire a scope of skills that you might not have otherwise. It's a generalist's dream!

There are reciprocal lessons for other physiotherapy practice areas. Allyship is not limited to working with Indigenous peoples. Given the various forms of systemic oppression, there are one or more ways in which the client you are treating is possibly disadvantaged. The experience of giving and receiving health care is rarely such that both persons have equal power in the interaction, and anything that brings that to a health professional's awareness and encourages them to mitigate as much as possible will lead to better care and teaching. We learn so much from listening to, and working with, our clients. This practice area can make you a better, more knowledgeable, more culturally sensitive PT and person.

Working in northern Manitoba is also fun! You take helicopters, planes, boats, hovercrafts, and medical vans to work. The Nursing Residence where you are staying may offer stunning views. You share accommodations with exceptional and inspiring health care professionals who have traveled from various parts of Canada to work in these communities. And you always have a good story to tell by the time you get back home.

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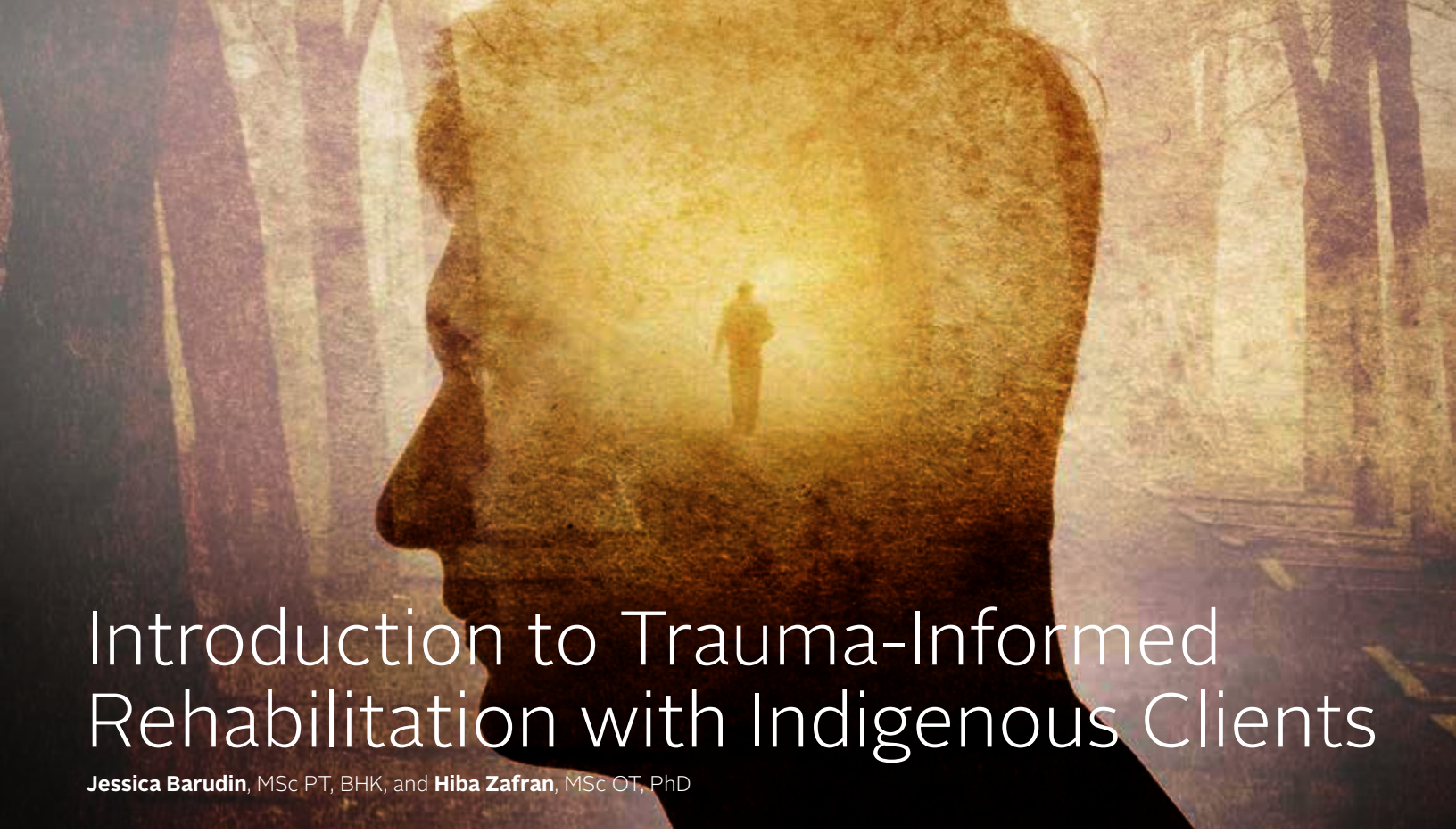

Introduction to Trauma-Informed Rehabilitation with Indigenous Clients

Jessica Barudin, MSc PT, BHK, and **Hiba Zafran**, MSc OT, PhD

Abstract

We are at a key moment in history where there is a national imperative for reconciliation with Indigenous Peoples in Canada. The health care system is one of the primary arenas where Calls to Action for safer and anti-oppressive health care must take place. The aim of this introductory paper is to define and discuss the importance of trauma-informed rehabilitation when working with Indigenous clients and in their communities, describe an Indigenous view on trauma and healing, and outline trauma-informed strategies for rehabilitation practitioners.

Introduction

The ongoing and multigenerational impact of colonization and disruption of language and culture are at the root of health issues impacting Indigenous population health in Canada. Ongoing unacceptable health and quality of life inequalities permeate throughout Indigenous communities, both on- and off-reserve. Indigenous peoples experience significantly higher rates of chronic and infectious diseases than their counterparts in Canada.[1] It is very clear that these inequities are not a result of individual lifestyle choices, but are rather due to the historical and sociopolitical injustices imposed on Indigenous communities in Canada (see Figure 1). Within health care services, workers have been involved in starvation studies on Indigenous children, and continue to be accountable for forced sterilization of Indigenous women and forcible removal of children from their parents.[1] This leads to both systemic racism and health states impacted by post-traumatic stress responses.[2] Yet, in health care, translating this knowledge into everyday practices is lagging. As part of a holistic approach to health and rehabilitation, a culturally-appropriate framework to understanding responses to trauma experienced by Indigenous peoples must include historical, social, and political factors, in addition to the physical manifestations of health conditions and injuries. The aim of this introductory paper is to introduce and discuss the importance of trauma-informed rehabilitation when working with Indigenous clients and in their communities, narrate differential Indigenous views on trauma and healing, and outline strategies for practitioners.

Conceptualizations of Trauma

The concepts and theoretical understandings of trauma has a complicated and controversial history and place in current practice with Indigenous populations. The impacts of psychological trauma, such as substance use and poor management of chronic health conditions, are often addressed within an individual and pathology-focused framework. Yet, by definition, psychological trauma is unique amongst the various categories of mental health because it is explicitly and directly caused by either experiencing or witnessing an external event that threatens one's life or the lives of those close to you.[3] Although clearly defined, the diagnostic category of Post-Traumatic Stress Disorder (PTSD) is problematic in situations where trauma and violence have been sustained over long periods of time. Another critique is that naming attempts to cope in the face of terrible events and losses as a 'disorder' locates the problem in the person, rather than the broader social processes that trigger and maintain these post-traumatic stress responses.[2] There are expanded understandings of trauma that account for the broader context in which trauma responses are elicited and maintained (see Table 1).

"As part of a holistic approach to health and rehabilitation, a culturally-appropriate framework to understanding responses to trauma experienced by Indigenous peoples must include historical, social, and political factors."

Complex Chronic PTSD (CC-PTSD) outlines the very different ways in which survivors of long-time violence develop, cope, and move through the world.[4] The individual who lives through repeated and prolonged violence comes to have 'shattered assumptions' about the world – they can no longer assume that they will be safe, that the world is safe, or that they are loveable.[5]

Transgenerational Trauma is when significant trauma is passed down within families due to the pervasive effects of CC-PTSD, whereby parental trauma impacts the development and worldview of children and grandchildren. Transgenerational Trauma is well documented within Indigenous communities and linked to chronic health conditions.[6]

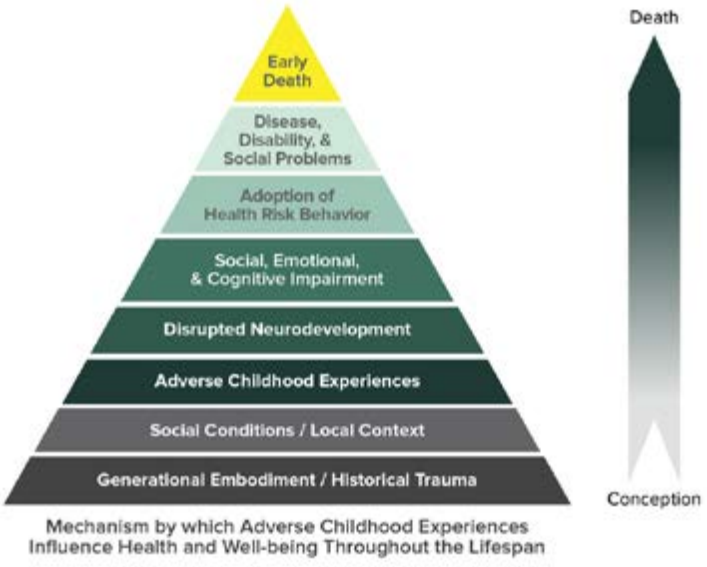

Figure 1 Mechanism by which adverse childhood experiences influence health and well-being throughout the lifespan

Source: Centers for Disease Control and Prevention https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-graphics.html

Historical Trauma (HT) is defined as cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma.[7] One-fifth to one-third of Indigenous adults reported thoughts pertaining to historical loss daily or several times a day, and that these thoughts have negative emotional consequences.[8] The theory of HT posits six kinds of unresolved collective grief for Indigenous peoples that are summarized in Table 2.

The concept of HT is most relevant here as it accounts for the depth and breadth of disconnections, violence, and colonial and political structures that perpetuate loss and impede healing. It should be noted that the term "historical" – although intended to capture the collective, governmental, and long-term nature of oppression - can be misleading. The losses and complex cumulative effects of trauma endured by Indigenous peoples are not confined to a single catastrophic period and continue to be reinforced through current political, social, and legal structures.[8]

Common observable responses in these expanded definitions of trauma range from the physiological, psychological, and the social. Individuals may have differential experiences of pain that can be either amplified or dissociated, leading to a much higher incidence of histories of trauma in individuals treated for chronic pain or fatigue challenges.[9] Experiencing loss of predictability and control also leads to the inability to trust oneself or others and can impact engagement in therapeutic relationships. Not feeling safe in the world naturally impedes the desire to move out into the world and therefore motivation for rehab goals. When trauma is collective, the impacts on cultural identity, community ties, and natural support systems as sources of resilience may be damaged or severed. Individuals may experience survivor's guilt, and feel that living a full life is a betrayal to one's ancestors' suffering, psychic numbing and a fixation on trauma, destructive behaviors such as substance use or passivity leading to

Table 1: Comparison between types of Trauma

Category	Definition	Trauma Type
Acute	Single, isolated incident	• Accident • Natural disaster • Single act of violence or terrorism • Sudden unexpected loss
Chronic	Traumatic experiences that are repeated or prolonged	• Prolonged family or community violence • Long-term illness • Chronic bullying • Chronic poverty and related stressors • Exposure to war, torture, or forced displacement
Complex	Exposure to multiple traumatic events from an early age, often within the caregiving system or without adequate adult support, which has short- and long-term effects in many areas	• Physical, emotional, and sexual abuse within caregiving systems • Ongoing neglect by caregivers • Witnessing domestic violence • Other forms of chronic violence without support
Historical & Racial	Collective and cumulative trauma experienced by a group across generations that are still suffering the effects and current experiences of race-based trauma	• Systematic oppression of particular groups across generations • Racism • Discrimination • Harassment

Source: National Centre on Safe Supportive Learning Environments / https://safesupportivelearning.ed.gov/understanding-trauma-and-its-impact

Table 2: Sources of Indigenous Historical Trauma

Phase	Key Inciting Processes for Collective Grief
1. Cultural Transition	*First contact:* Introduction of disease and alcohol with ensuing physical decimation of the population *Economic stripping:* Loss of stewardship of the land and traditional ways of life
2. Cultural Dispossession	*Invasion:* Christian missionaries and prohibition of Indigenous ways of life, widespread racism, and non-respect of the Treaties *Subjugation/reservation period:* Implementation of political rule and colonial settlement, and segregation within reserves
3. Cultural Oppression	*Genocide:* Widespread implementation of residential schools with the destruction of family systems (e.g. 60's and millienial scoops); loss of language and cultural ties *Forced relocation and termination period:* Transfer to urban areas; racism and being viewed as second class; loss of communities and self-governance; ongoing murder of Indigenous women and girls

Adapted from: Aboriginal Healing Foundation (2004). / http://www.ahf.ca/downloads/historic-trauma.pdf

poor health management, and internalization of racism.[10] The behaviors of individuals with complex, transgenerational, and/or historical trauma do not fall neatly into the psychiatric diagnosis of PTSD, and can be misinterpreted as manipulative, disengaged, or unmotivated when, in fact, these behaviors make sense as responses and attempts to cope with trauma and violence, particularly when the trauma has been perpetrated within health care systems.

Indigenous Worldviews of Trauma and Healing

"The medicine is already within the pain and suffering. You just have to look deeply and quietly. Then you realize it has been there the whole time." ~ Proverb from Indigenous Oral tradition

Beyond critiques of the conceptualizations of PTSD, this paper now shifts towards Indigenous views on trauma and healing which, unlike Western conceptualizations of disease and cure, are inextricable from each other. Trauma and healing occur within an interconnected social and natural web. Trauma is known as a "soul wound" in many Indigenous Nations. A soul wound is described as a spiritual injury, ancestral hurt, and a sickness of the soul.[11] In this understanding, trauma that spans across generations is referred to as passing on the hurt with cumulative effects. With respect to Indigenous worldviews of the interrelated domains of body, mind, and spirit, the physical pain is not separate from the emotional, cultural, spiritual, or ancestral pain. This understanding of trauma goes beyond human exchange and sociopolitical dimensions, when we grasp the oral tradition of all Indigenous peoples, which speaks of our interconnectedness to all of creation and our original instructions to be caretakers of the earth. Thus, when in addition, Indigenous lands have been stolen and stripped for their natural resources, this compounds the soul wound.[11] The experience of Indigenous individuals cannot be separated from environmental crises, as well as the ongoing genocide of Indigenous women and girls.[12]

Integrating a cultural and spiritual framework are unique considerations and approaches for rehabilitation practitioners when working with Indigenous clients and populations. That is, understanding how Indigenous clients relate to, and express, concepts of healing, wellness, balance, disease, and pain are important to discern throughout the rehabilitation journey. For example, it may be fruitful to discuss dreams relating to their condition/injury or healing.

Biomedical and rehabilitation practices, when applied in parallel with core cultural and spiritual practices, have a potential to heal soul wounds and enhance resiliency. Indigenous cultural practices have been passed on by oral traditions. They strengthen relationships with ancestors, self, kin, community, land, and Nation. Examples include:

- Ceremonial practices, such as a Sweat Lodge, Sundance, Pipe Ceremonies, and Healing Circles
- Land-based healing*,[1] such as traditional food and plant harvesting, gardening, and preparing for ceremonies
- Revitalization of traditional language and cultural practices for connection and empowerment, e.g. traditional dancing, sports, and games

Strategies for Trauma-Informed Therapists

"Every [Indigenous person] has a story to share, but not everyone is prepared to hear it." ~ Nadine Caron, MD, Anishnawbe from Sagamok First Nation

Indigenous clients accessing rehabilitation will present with variations of individual and collective trauma and healing histories. Historical trauma and oppression are likely directly causing and contributing to the presenting condition and functional issues, and being within the health care system may be aggravating possible trauma-related experiences. "Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma" (http://www.traumainformedcareproject.org). This does not mean specifically treating trauma, but rather being aware of, and accounting for, the greater need for safety and trust within health care. The following are core principles of trauma-informed care that are built around the power-dynamics that are inherent in (re)producing trauma.[13] Strategies in rehabilitation for each of these principles are compiled from multiple sources[10,13-15] and the authors' own practices.

Respect: This is a key value across all Indigenous Nations and requires humility from the rehabilitation practitioner. Apply active listening practices and allow an adequate pace for history taking. Provide time at the start and end of each session for dialogue. Conceptualize your role as an ally to their healing process, with a willingness to learn.

Safety: In acknowledging that physical therapists working within health care are seen as representatives of a colonial system, you cannot assume that a client feels safe with you. There is a need for patience and time to develop trust. Recognize and validate feelings of

*Not all Indigenous peoples have access to their traditional territories or to communities who can guide them

mistrust. To avoid re-traumatizing individuals, maintain a calm and non-judgmental demeanor and dialogue. Touch and physical manipulations can be triggering and tricky in physical therapy. Take the time to first enter into dialogue before initiating therapeutic touch. Make sure to always explain what you propose to do and why, and ensure consent at each step of the way.[16]

Create a healing container: Consider including culturally appropriate symbols of safety and respect within your care setting, such as symbols of the Nations within your region, or local Indigenous art. Find spaces for privacy for interviews and sessions that are quiet and serene. Try and book sessions on the same days and times, as routines and predictability are helpful.

Transparency: HT is enforced by secrecy and intentional ignorance. Therefore, be transparent about the limitations of services and of your knowledge. Be very explicit about your role and intentions and leave plenty of room for questions and real shared decision-making, especially with goal-setting. Individuals may not feel comfortable or empowered to ask, but, over time, this is also a strategy for fostering safety.

Collaboration: A trauma-informed paradigm is led by the client. Some opening questions for working with Indigenous individuals include:

- What would you need to feel healthy/strong through this injury/illness/disability/challenge in your life?
- What's strong with you?
- Would you like to tell me about your family/ancestors/community?
- How would you like me to support your healing?
- What does healing mean for you?

Collaboration includes building relationships with local Indigenous community organizations for opportunities for professional development, as well as awareness of local cultural resources for your Indigenous clients.

Empowerment: This involves a focus on relationship building, as well as strengths-based approaches and connection to community ties. Support your client in developing self-advocacy skills, understanding their triggers, integrating strengths-based indicators for the client to identify, and encouraging the client to draw upon connections to family and community support and resources, when appropriate.

Choice: Make sure that your client has a real choice in their treatment plan and how they wish to (or not) integrate with traditional approaches to healing, which health care provider they prefer to work with in terms of safety (could be a gender preference, for example), or who comes with them to appointments. As one example of the insidious nature of lack of choice and ongoing harm, a residential school survivor who no longer has a community network and is forcibly placed in long-term care is effectively being re-traumatized and colonized by the actions of the state.[17]

Final Cautionary Notes

- Do not pan-Indigenize and assume that either Indigenous peoples from different Nations or from the same communities have had similar experiences or hold similar beliefs
- Refer to other health professionals or a spiritual counsellor/healer when the client is in apparent crisis
- Avoid authoritative voices and policies; be careful not to re-traumatize
- Question labels such as 'noncompliant', 'unmotivated', and 'against medical advice' from the perspective of normal human responses to trauma and oppression

Conclusion

Learning about historical trauma and the ways in which systemic racism is present in health care is a necessary action for rehabilitation practitioners. Developing the attitudes and skills for trauma-informed care, and the humility to learn about Indigenous worldviews of healing, is a responsibility that is necessary and meaningful in order to move towards safe and effective outcomes with Indigenous clients.

About Jessica

Jessica Barudin is Kwakwaka'wakw from the 'Namgis First Nation. She is a mother, Sundancer, yoga teacher, and Indigenous health advocate. She is stepping into a new role with the First Nations Health Authority in community engagement and beginning doctoral studies at Concordia University. **jessica@cedarandgold.ca**

About Hiba

Hiba Zafran is an occupational therapist-psychotherapist and Assistant Professor (Teaching) at McGill University's School of Physical and Occupational Therapy. Her clinical expertise includes grief and trauma counselling. Her current focus is on developing the competencies of health care professionals to work with Indigenous communities. **hiba.zafran@mcgill.ca**

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A Physiotherapist's Response to Mobilizing Reconciliation

Bonnie Tinker, BMR PT

The *Final Report of the Truth and Reconciliation Commission of Canada*[1] was released in June 2015. In the editorial *Mobilizing Reconciliation: Implications of the Truth and Reconciliation Commission Report for Physiotherapy in Canada*, Gasparelli, Crowley, Fricke, McKenzie, Oosman, and Nixon (2016) list four Calls to Action for individual physiotherapists: (1) Read the TRC report; (2) Listen to the TRC report being read; (3) Advocate for others in physiotherapy and health care more broadly; to read and disseminate the report and its recommendations; (4) Respect and acknowledge the diverse personal histories of Indigenous individuals who are seeking physiotherapy services, so as to provide care in a culturally safe and humble manner. I work as a school physiotherapist and therefore work with many Indigenous children and families. The Calls to Action by Gaparelli et al. (2016) highlighted my responsibility as a physiotherapist, and Canadian, to learn more in this area to help provide culturally safe and humble care. I responded to their Calls to Action by registering for a self-directed studies course with the University of British Columbia (UBC) so that I could devote a semester of study to their four Calls to Action.

The steps that I took to respond to the four Calls to Action by Gasparelli et al, (2016) included: reading the TRC Summary, listening to the TRC Summary being read, advocating for others to read the TRC Summary, and completing a literature search on the question "How have physiotherapists and occupational therapists responded to the Truth and Reconciliation Commission's Calls to Action, and what are the recommendations for cultural safety, cultural humility, decolonization, and reconciliation in relation to their practice?"[2] The goal of my self-directed course was to translate the knowledge gained from responding to the four Calls to Action into practical steps to provide care in a culturally safe and humble manner for the Indigenous children and families I work with.

Call to Action: Read the TRC Summary

The Final Report of the Truth and Reconciliation Commission of Canada Volume One: Summary Honouring the Truth, Reconciling for the Future[1] summarizes the commission's activities, the history of the IRS, the legacy of the IRS, and the challenge of reconciliation. The TRC Summary is a well written book written in plain language, making the message accessible for all Canadians. Reading the TRC Summary dispelled many inaccurate ideas that I had and broadened my understanding of the history and legacy of the IRS.

When discussing colonization and the journey of reconciliation, many Canadians say, "It is such a big problem; what can we do?" I am thankful that the TRC not only detailed the history and legacy of the IRS, but they have also outlined 94 clear Calls to Action that can be taken to help reconcile and heal our nation, ranging from personal actions all the way up to the level of our provincial and federal governments.

Call to Action: Listen to the TRC Summary Being Read

Listening to the TRC Summary being read is a very emotional experience. It is one thing to read the words describing the historical and present-day treatment of Indigenous peoples, but it is another thing to listen to someone read the words about the cultural genocide that the Government of Canada completed against their culture. Listening to Indigenous Canadians read the TRC Summary moves the written words from the head to the heart.

Call to Action: Advocate for Others to Read the TRC Summary

Learning about the history of colonization and the legacy of health inequities and racism that Indigenous peoples face should be an essential understanding for all Canadians. The TRC Summary title includes the phrase, "honouring the truth and reconciling for

the future." To go forwards in a path of healing, it is essential that Canadians understand the past. After reading the TRC Summary, I have begun advocating for others to read the TRC with the hope that increased knowledge of Canadian history will encourage my friends, family, and colleagues in the journey of reconciliation.

Call to Action: Provide Physiotherapy Care in a Culturally Safe Manner

My literature search question, "How have physiotherapists and occupational therapists responded to the Truth and Reconciliation Commission's Calls to Action, and what are the recommendations for cultural safety, cultural humility, decolonization, and reconciliation in relation to their practice?"[2] and a comprehensive literature search yielded 53 articles related to the topic. Four themes emerged: (1) the TRC and responses from health care providers; (2) cultural humility and cultural safety; (3) recommendations for changes in curriculum for health care providers in response to the TRC; and (4) practical tools and applications for health care providers to promote reconciliation within their personal and professional lives.

Theme One: TRC and Responses from Health Care Providers

Ten articles and one report were reviewed that discussed the topic of the TRC and the response of health care providers. A common message for health care providers is that they need to read the TRC report and learn more about the legacy of the treatment of Indigenous peoples in Canada, and that colonization is a social determinant of health for Indigenous Peoples.

Restall, Gerlach, Valavaara, and Phenix (2016) feel that "nothing about us, without us" is a central starting point for considering reconciliation work and improving the health outcomes of Indigenous Peoples. Katz, Enns, and Kinew (2017) echo this in their article, saying, "we need to recognize that First Nation peoples as their own best resource, and prioritize the creation of a national strategy that respects and implements a holistic First Nations-focused approach to health."[3] The articles emphasize cultural safe practices as an important practice for health care providers. Many of the articles advocate for changes to the curriculum for health care providers following the recommendation from the TRC's Calls to Action. Finally, the importance of top-down, institutional change is advocated for by Vogel (2016) and this is echoed in many of the other articles reviewed.

Theme Two: Cultural Humility and Cultural Safety

Fourteen articles and one report were reviewed that discussed the topic of cultural humility and cultural safety. Gerlach (2012) discusses the concept of cultural safety and suggest that it is a complex term that encompasses social justice and equity. It requires that health care providers self-reflect on the power imbalances and personal biases that may contribute to health inequities for Indigenous peoples. In another article, Gerlach (2015) highlights the importance of focusing on the strengths, agency, resiliency, and capabilities of marginalized populations rather than on needs and problems.

In the article, *Cultural Humility: A Concept Analysis*[4] the authors describe the attributes of cultural humility as openness, self-awareness, egoless, supportive interaction, self-reflection, and critique. They outline the consequences of cultural humility as mutual empowerment, partnerships, respect, optimal care, and lifelong learning.

Theme Three: Recommendations for Curriculum Changes

The TRC's 23rd Call to Action recommends cultural competency training for all health care professionals. In 2013, the National Collaboration Centre for Aboriginal Health released the report *Cultural Safety in First Nations, Inuit and Metis Public Health* (Baba, 2013). The report details an environmental scan that looked at the cultural safety curriculum and initiatives implemented by various organizations throughout the country. The report recommends the development of standardized assessments of cultural safety programs and a set of core competencies for Aboriginal public health (Baba, 2013).

Guerra and Kurtz (2017) completed a scoping review of cultural competency and safety education for health care students and professionals in Canada, and they recommend that experiential learning is critical and that cultural safety programs should be mandatory in health organizations. Guerra and Kurtz (2017) encourage the concept of cultural safety, not only in our professional lives, but in our personal lives as well:

> *...the merit of cultural safety as a concept has now been well-established and its role in the delivery of healthcare increasingly accepted. The battle now raging finds us seeking to effectively translate the wisdom of a culturally safe approach to humanity into the subtlety of everyday encounters, where such humility and respect have been too long forgotten. It is time to stop struggling asynchronously and instead to build and integrate the concept of a culturally safe encounter into the fabric of society and our everyday lives with all people, not only Indigenous populations.*[5]

Theme Four: Practical Tools and Applications for Reconciliation

The eight articles and one report reviewed provide many practical ideas to promote reconciliation and decolonisation. McGibbon (2019) discusses that addressing white settler power and privilege is a cornerstone of decolonization. McGibbon (2019) further explains that if Indigenous Peoples are suffering racism and health inequalities, the other side of the coin is white privilege. Holm, Rowe-Gorosh, Brady, and White-Perkins (2016) also discuss privilege and bias, including an interactive Privilege and Responsibility Curricular Exercise tool they developed to assist people to become conscious of the invisible privileges that they have in society.

Gerlach and Smith (2015) discuss the importance of understanding history and understanding trauma and promote the use of trauma informed practice with Indigenous peoples. They suggest that,

> *Occupational therapists need to pause and consider how some of their ways of being and practicing may be a trigger for some Indigenous clients. Examples of this might include wearing a uniform, focusing on paperwork, asking lots of questions, or rushing in and doing an assessment rather than spending time building a trusting relationship and listening and learning from clients."*[6]

Masters, Robinson, Faulkner, Patterson, McIlraith, and Ansari (2018) provide a clinician coaching tool for cultural humility. Masters et al. (2018) recognize that everyone has implicit biases and having a tool to help guide self-reflection in this area is beneficial. The authors discuss the "5Rs of Cultural Humility," including reflection, respect, regard, relevance, and resiliency. The authors provide both a learning aim and a question for each of the R's to help guide clinician self-reflection.

Action Recommendations

Gerlach and Smith (2015) write, "I understand differently now and, therefore, I will act differently."[6] The main goal of my self-directed course was to translate the knowledge gained from responding to the

four Calls to Action into practical steps to provide care in a culturally safe and humble manner for the Indigenous children and families I work with. With this goal in mind, I have compiled practical action recommendations for health care providers from the readings reviewed in my literature search:

- Ground policy decisions on the United Nations Declaration on the Rights of Indigenous Peoples (Bourque-Bearskin, 2016)
- Implement cultural safety training for employees (McGibbon, 2019)
- Use the 5 Rs (reflection, respect, regard, relevance, resiliency) to reflect on your own biases in daily practice (Masters et al., 2018)
- Review the Privilege and Responsibility Curricular Exercise tool to reflect on power and privilege (Holm et al., 2017)
- Display Northern Health Cultural Safety posters in the workplace as reminders to staff and clients (Greenwood, 2018)
- Learn from clients, not about clients, and recognize the importance of relationships (Gerlach et al., 2016)
- Practice in a trauma informed model of care (Gerlach & Smith, 2015)
- Learn Motivational Interviewing to help learn language that places the health care provider as partner with the client
- Advocate for others to read the TRC (Gasparelli et al, 2016)
- Learn more about the Indigenous Peoples that you live and work with, and about the history of the treaty area you live in (McGibbon, 2019)
- Partner with Indigenous peoples when implementing policy decisions to ensure that they really are culturally safe (McGibbon, 2019)
- Use assessments cautiously with Indigenous children and families (Gerlach, 2018)
- Take open access cultural safety from organizations like University of Victoria's nursing program (Baba, 2013), I*ndigenous Initiatives* (https://www.uvic.ca/hsd/nursing/undergraduate/transfer/resources/indigenous/index.php) or Anishnawbe Health Toronto's program, Aboriginal Cultural Safety Initiative (https://www.aht.ca/component/content/article/91-acsi/104-aboriginal-cultural-safety-initiative).
- Adopt a strength-based approach with clients and families, and really focus on strengths, not deficits (Gerlach, 2018)
- Learn more about the medicine wheel as a holistic perspective on health and wellness (Hojjati et al., 2018)
- Take Indigenous Canada's Massive Online Open Course (Baba, 2013) (https://www.coursera.org/learn/indigenous-canada)

Conclusion

Colonisation and racism are social determinants of health for Indigenous peoples in Canada with resulting health inequities. The TRC Summary (2015) explains the history and legacy of the Indian Residential School system and the challenges for reconciliation that Canada faces. In the closing pages of the TRC Summary report, the authors discuss that,

> *Reconciliation is going to take hard work. People of all walks of life and at all levels of society will need to be willingly engaged. Reconciliation calls for personal actions. People need to get to know each other. They need to learn how to speak to and about each other respectfully. They need to learn how to speak knowledgeably about the history of this country. And they need to ensure that their children learn how to do so as well.*[7]

Discussing the health inequities and racism that Indigenous peoples face causes settlers to self-reflect on white power and privilege, and turn the rocks over in their own gardens (Regan, 2010). With the knowledge gained from the background and literature search readings, I have found that there are many actions that can be taken to promote reconciliation, decolonization, and respectful relationships. We are all treaty people and reconciling for the future will not only take a change in minds and hearts, but in actions as well.

About Bonnie

Bonnie is a physiotherapist and she has enjoyed working in a variety of practice areas throughout her career. In the past, Bonnie has worked in Nunavut, northern British Columbia, and Manitoba, and has valued her experiences working with First Nations, Inuit, and Métis families. At present, Bonnie works as a school physiotherapist and loves collaborating with students, families, and teachers.

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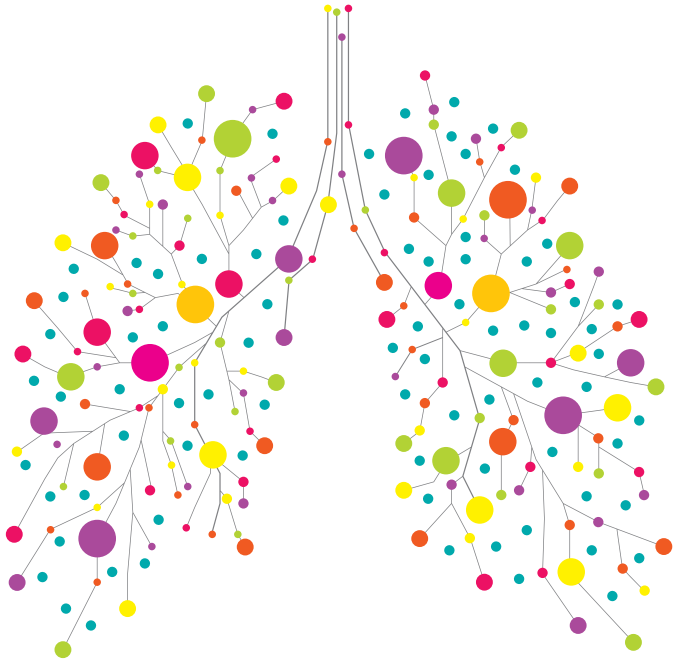

Jennifer O'Neil, PT, PhD (candidate), CPA Member since 2009;
Simone Gruenig, PT, MSc, CPA Member since 2009; and
Dr. Pat Camp, PT, PhD, CPA Member since 1993

The Cardiorespiratory and Global Health Divisions of CPA partnered together to complete a remote interview with Dr. Pat Camp. The objective of this collaborative interview was to showcase how clinicians can combine interests and practice fields. Dr. Camp is a great example of how to successfully achieve integration of both cardiorespiratory expertise and global health principles, while successfully collaborating with different groups. In her current work, she demonstrates cultural poise in conjunction with the quest to raise lung health awareness in rural and Indigenous communities. We have highlighted the following from the interview:

- *lung health priorities*
- *working with Indigenous communities*
- *leading a culturally safe practice*
- *expert 'tips of the trade'*

Dr. Camp is a physiotherapist, clinician-scientist, and principal investigator at the University of British Columbia (UBC) Centre for Heart Lung Innovation, and director of the Pulmonary Rehabilitation Research Laboratory at St. Paul's Hospital in Vancouver, British Columbia. Her collaborative research is devoted to two main areas: Indigenous health and respiratory health, specifically COPD.

In collaboration with Carrier Sekani Family Services (CSFS), Dr. Camp is currently working on an integrative project combining Indigenous and respiratory health. For the last 25 years, CSFS has been providing holistic health to their member nations in British Columbia. The CSFS mission statement is: "With the guidance of our elders, Carrier Sekani Family Services is committed to the healing and empowerment of First Nations Families by taking direct responsibility for health, social, and legal services for First Nations people residing in Carrier and Sekani territory."[1] The CSFS uses culture, which has been passed down through their ancestors, as a base for their care and uses the Carrier Life Cycle Model for the approach to provision of service.[1] They also exercise their rights to be self-determining for the needs of their communities.[2]

Forming a culturally-safe partnership was crucial to Dr. Camp's and CSFS Executive Director of Research, Primary Care and Strategic Service Dr. Travis Holyk's success in receiving funding for their current initiatives. The relationship first started several years ago with UBC and CSFS's development of a clinical placement site for the physiotherapy students at UBC in some of the different First Nations communities where CSFS provides primary care services. The relationship evolved over time through trust and communication. Discussions were held about lung health and focus was placed on building trust. Now, it has grown to the point where successful research collaboration is present and active. Dr. Camp and Dr. Holyk have been funded five grants and one is currently under review. The success in funding demonstrates the CSFS mandate to provide self-determining research projects that are responsive to community needs and that directly benefit the communities they service.[2] The funding success also demonstrates the importance of key partnerships and engaging in a culturally safe practice.

In all trustworthy partnerships, mutual and equitable benefits must be achieved. The grants will allow Dr. Camp and her team to contribute to lung health research, while ensuring that the communities can directly benefit from the research being conducted. One example Dr. Camp explained of how this is being done is, "Anything that we do has to have a benefit for the community. If we have a spirometer that we are going to use for the study, we will make sure that the community gets to keep it at the end, and we will also provide training so they can use it and it can be a service and improvement to care that can be sustainable." In this way, the communities increase their ability to measure lung function and not have their members leave their respective communities in order to obtain this important test. Again, this partnership allows to improve access to lung function measurements while remaining within the CSFS's mission of empowerment and self-determination.

While Dr. Camp is very pleased to offer these opportunities through her research collaborations with CSFS, she recognizes that it is important to remain culturally safe. Cultural safety encompasses cultural humility and health literacy. Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.[3] Dr. Camp would advise to "recognize that a westernized way of acquiring knowledge and dissemination might not necessarily be considered culturally safe." Reflecting on our behaviours, exercising critique, and recognizing power dynamics and privilege daily can help facilitate a life-long journey of culturally safe practice. Dr. Camp states, "We need to be mindful and cautious, and recognize that we

"Some of their future long term goals are to understand how to address the pulmonary rehabilitation needs, the role of telehealth and pulmonary rehabilitation, and how to ensure sustainability of lung health programs to these remote communities."

are a guest on their land. And be grateful for the opportunity."

Dr. Camp's journey towards a culturally safe practice included personal and formal training, and she subscribes to the philosophy of it being a lifelong process. Her personal learning was, but is not limited to, reading the Truth and Reconciliation Report,[4] subscribing to different Indigenous health groups bulletins and exposing herself to issues, questions, and concerns that arise. Formal training for the research team is with the CSFS cultural training program.

The future currently looks positive. Dr. Camp and her small research team are working directly with CSFS and are traveling to the communities every 4-8 weeks. Some of their future long term goals are to understand how to address the pulmonary rehabilitation needs, the role of telehealth and pulmonary rehabilitation, and how to ensure sustainability of lung health programs to these remote communities. It is also important to note that one tool that Dr. Camp has learned about cultural safety is "to not make an assumption on how things are conducted, ask questions, and understand the processes that are in place and respect that. Respect that the Western ways are not the right way; there is more than one right way to do things."

As Jawaharlal Nehru once said, "Culture is the widening of the mind and of the spirit." While engaging in culturally safe practices is not always stressed in current physiotherapy curriculums, it is crucial to develop these skills, set time aside to reflect on our behaviours and recognize the daily impact of our actions in different cultural settings. We encourage all physiotherapists to engage in culturally safe practice and seek to further their education on this topic.

If you are interested in this type of research and collaborative work, Dr. Camp is currently seeking graduate students to join her team.

Jennifer O'Neil and Simone Gruenig conducted the interview with Dr. Pat Camp in February 2019. The intent was to provide the reader with an introduction to some of the research currently being conducted on lung health in remote communities. This was a first of many inter-division collaborations leading to knowledge dissemination of lung health and cultural safety. For physiotherapists with an interest, or who would like to be involved in the research, please contact Dr. Pat Camp at the University of British Columbia (see contact email below). For division related questions, contract Jennifer O'Neil (Knowledge Translation Representative of the Global Health Division) or Simone Gruenig (Chair of the Cardiorespiratory Division).

About Jennifer

Jennifer O'Neil is a physiotherapist and PhD candidate in the School of Rehabilitation Sciences, Faculty of Health Sciences, University of Ottawa, under the supervision of Heidi Sveistrup. She is a clinician-researcher focusing on improving access to rehabilitation care with the use of technology. Jennifer is also a Knowledge Translation Representative of the Global Health Division of the CPA.

About Simone

Simone Gruenig completed her undergraduate degree at the University of Ottawa and her Master's degree at the University of Toronto. Her graduate research focus was on post-operative thoracic patients. She has been part of the Physical Therapy Department at the University of British Columbia since 2008 as a course coordinator and instructor. She is also Chair of the Initiatives for Indigenous Advocacy Committee. Her clinical areas of practice have been in the acute surgical, palliative, and community patient populations. She also volunteers within the sport of Wheelchair Rugby as a classifier.

About Pat

Dr. Pat Camp is a physiotherapist, clinician-scientist, and principal investigator at the University of British Columbia (UBC) Centre for Heart Lung Innovation, Associate Professor in the UBC Department of Physical Therapy, and director of the Pulmonary Rehabilitation Research Laboratory at St. Paul's Hospital in Vancouver, British Columbia. Her collaborative research is devoted to two main areas: Indigenous lung health, and pulmonary rehabilitation (including projects in telehealth and rehabilitation for individuals with an acute exacerbation of COPD). Pat.camp@hli.ubc.ca / www.prrl.rehab.med.ubc.ca / Twitter: @UBCPulmRehabRes

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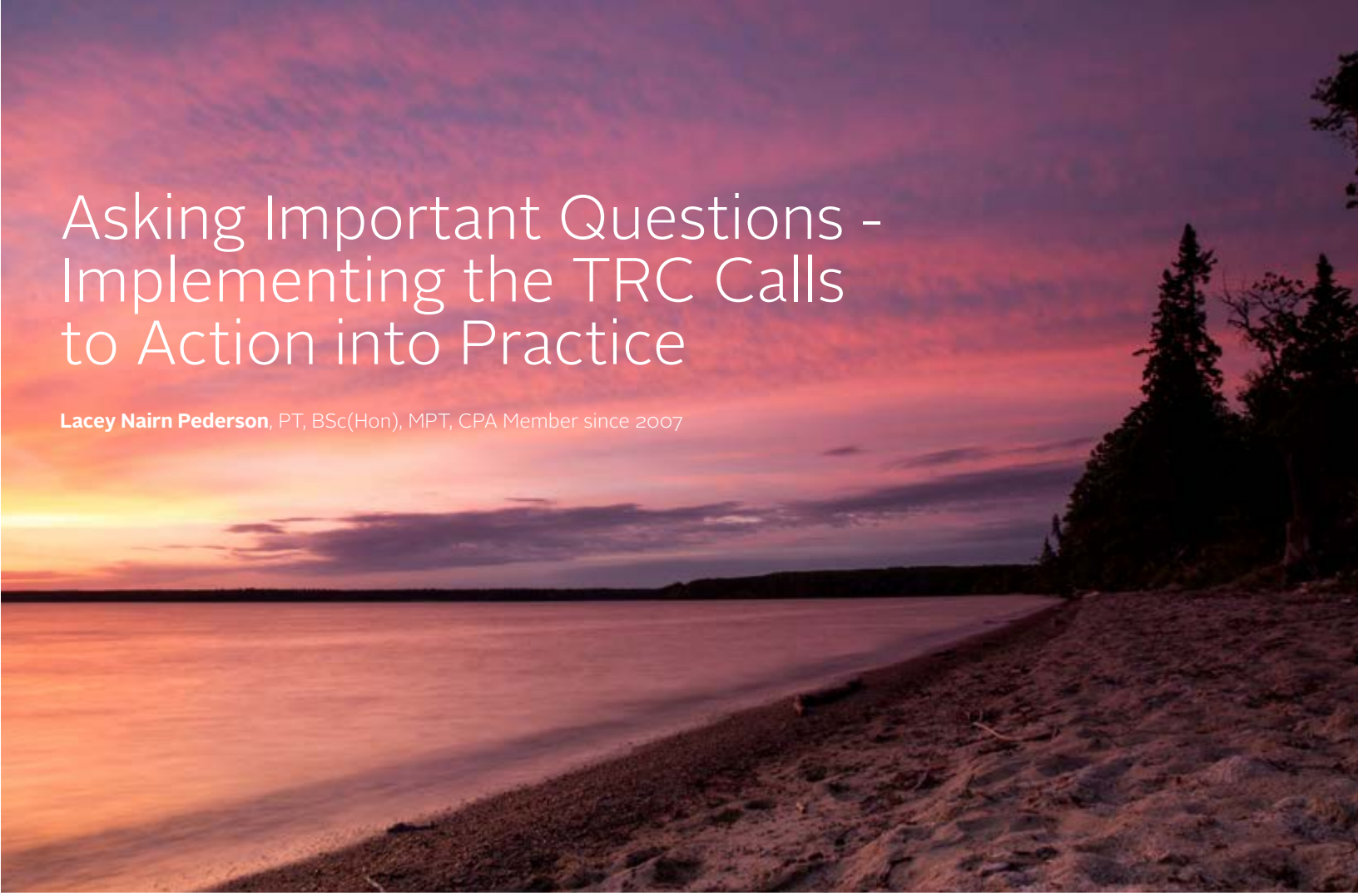


Asking Important Questions - Implementing the TRC Calls to Action into Practice

Lacey Nairn Pederson, PT, BSc(Hon), MPT, CPA Member since 2007

Physiotherapists are hardworking and conscientious professionals. We strive to be evidence-based and implement the most recent trends in our work. In a time when there are many conversations surrounding Indigenous health, some questions to ask are: How are we incorporating the TRC Calls to Action into the approach that we currently use? Has this changed our work and perspective on Indigenous health?

Over the last few years, I have put much thought into this, as a physiotherapist, coming from a settler family, as a community member in a province with a large proportion of people who are Indigenous, and as an ally. In my practice there are three areas I prioritize when applying the Calls to Action, and these areas also prompt me to consider many questions along the way.

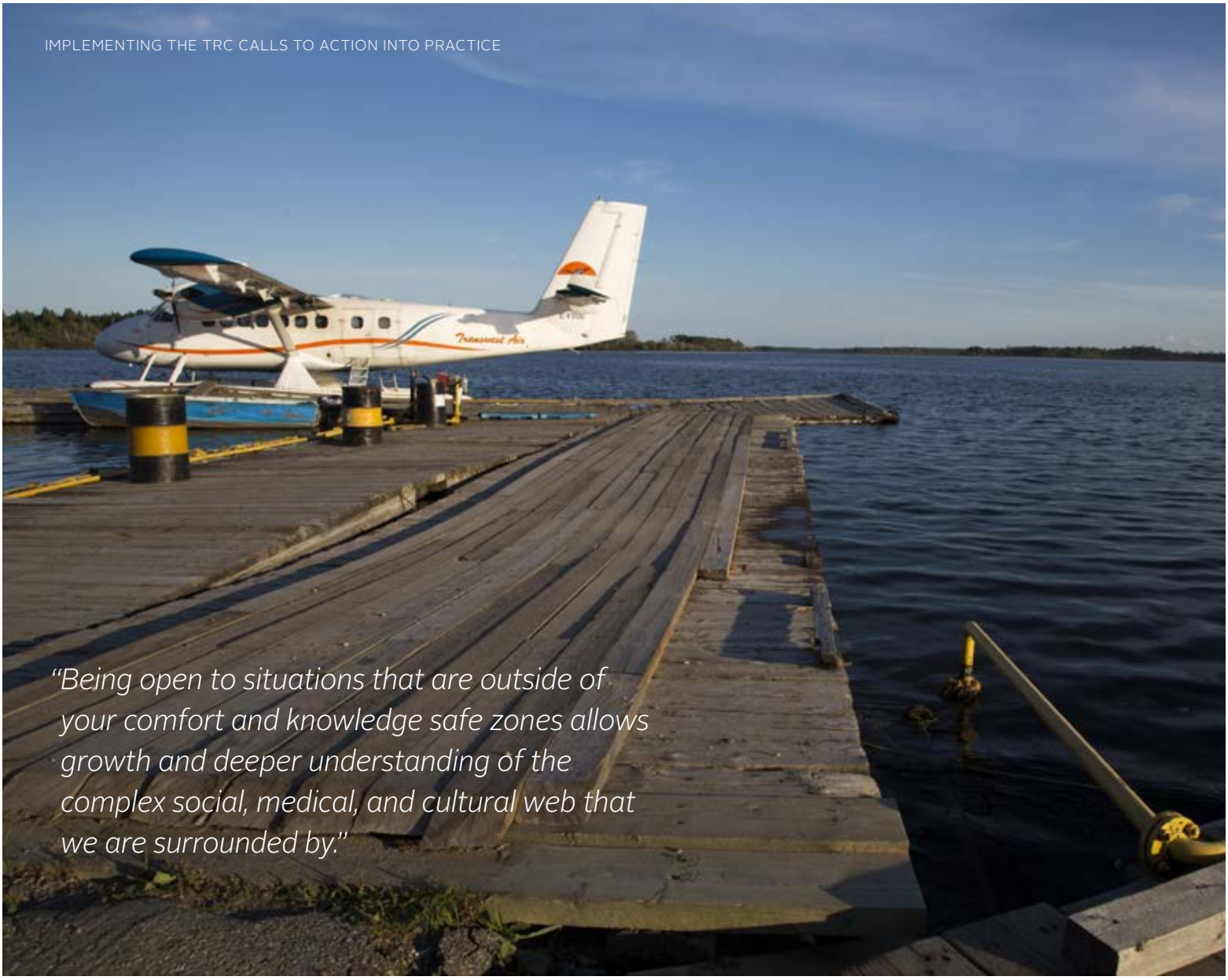
In Daily Practice

The TRC Calls to Action relating to health care calls "upon those who can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices, and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients" (TRC of Canada, 2015). In our daily work as therapists, there is the opportunity to give space for conversations around Indigenous healing practices. The facility that I work in has started to consider this and allows for Smudges at the bedside, as well as a ceremonial space that can be used. I'm conscientious to allow time within a therapy session to ask questions regarding beliefs around healing practices, which brings a variety of answers, many of which are linked with the spiritual and emotional side of healing. As physiotherapists, being open to these conversations is key. Sensitivity around previous trauma is imperative, along with creating a safe space to allow Indigenous clients to be comfortable and heard. As a lifelong learner, spending the time to reflect on approaches used helps to foster further growth. Ask yourself - How can you recognize the value of Indigenous healing practices? Link that with your daily work, and provide space to start conversations on cultural healing practices and strategies. How does this change your approach?

In the Community

As physiotherapists, we belong to a professional community, as well as the larger community that we reside in. We have a role to engage with these communities and participate in conversations that will further our understanding of working with people who are Indigenous.

In Saskatoon, one example of this in our community is a student-run clinic within the downtown core that services largely an Indigenous population. The SWITCH (Student Wellness Initiative Towards Community Health) Clinic has wellness programming, an Elder, child care, a meal, and access to a medical team of students who work alongside mentors from a variety of professions (social work, medicine, nursing, pharmacy, and physiotherapy, to name a few). The vision and values of this clinic are parallel with my beliefs that working as an interdisciplinary team in a culturally safe environment can have lasting effects on the population that it serves and the health care practitioners that learn there. Spending time with an Elder and having conversations with community members has added depth to my understanding of the social determinants of health that are evident here. There may not be a specific clinic or an exact opportunity such as this within every community, but searching out chances to be available as a professional and an ally will, in turn, help to develop positive relationships and growth. Ask yourself – How can I be involved in my surrounding community's conversations around Indigenous health? How can I improve my understanding of Indigenous Health in the area I live in?



"Being open to situations that are outside of your comfort and knowledge safe zones allows growth and deeper understanding of the complex social, medical, and cultural web that we are surrounded by."

In the Larger Province/Country

It can be overwhelming to consider how you can effect change in your province or at a national level. Small steps can help to gain momentum. In the fall of 2017, I was fortunate to have the opportunity to live in a northern Saskatchewan community and work as a physiotherapist. Being open to situations that are outside of your comfort and knowledge safe zones allows growth and deeper understanding of the complex social, medical, and cultural web that we are surrounded by. Seeking out opportunities to work outside of urban centres and spending time within Indigenous communities has led me to gain perspective as an individual and therapist. When an Indigenous individual tells me about fishing, and stresses the importance as part of their livelihood, I have an appreciation of the significance of this. When humor is used as a way to bond and develop relationships, I am now assured that it is not an uncommon strategy. As physiotherapists, we have a role to advocate for equitable access to therapy services as well. Take a look around your area and find inequities to focus advocacy work on. Ask yourself - What is my understanding of communities outside my own within my province? How can I learn more? Are services accessible and can I have an impact on this?

Throughout this article there are likely more questions to consider than answers, and these questions highlight the vulnerability and openness we need as professionals to work with Indigenous people. We need to take time to reflect and consider what our role is and challenge ourselves, as well as our peers, to consider how to implement the Calls to Action into the daily work that we do.

About Lacey

Lacey Nairn Pederson is a Saskatchewan born physiotherapist who was shaped by growing up on a farm in a small community. Her career has been mainly at an urban acute care center in the core neighborhood of Saskatoon as a generalist with a love of geriatrics. She is also the President of the Saskatchewan Physiotherapy Association. Lacey spends time with her husband and two dogs, crocheting, running, and gardening.

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A Review of Western Canadian Physiotherapy Schools' Indigenous Admissions and Curriculum

Simone Gruenig, PT, CPA Member since 2018; **Lisa Jasper**, PT, CPA Member since 1995; **Moni Fricke**, PT, CPA Member since 2001; **Sarah Oosman**, PT, CPA Member since 1998; **Peggy Proctor**, PT, CPA Member since 1984; and **Robin Roots**, PT, CPA Member since 1997

The Truth and Reconciliation Commission (TRC) Report was published in 2015, and since then many physical therapy academic education programs across Canada have been responding to the Calls to Action in meaningful and relevant ways. Specifically, several Canadian Physical Therapy programs have been focusing on recruitment and retention of Indigenous physical therapy students and on implementation of cultural humility education related to Indigenous health topics that are pertinent to entry-to-practice physiotherapy competency in Canada. This article will highlight initiatives taking place across Western Canada, including the Universities of Alberta (UofA), British Columbia (UBC), Manitoba (UofM), and Saskatchewan (UofS).

Given the TRC Call to Action Number 23, we call upon all levels of government to:

i. Increase the number of Aboriginal professionals working in the health care field.
ii. Ensure the retention of Aboriginal health care providers in Aboriginal communities.
iii. Provide cultural competency training for all health care professionals.

Admissions

Admission into Canadian Physical Therapy education programs is an obvious place to initiate change in order to ensure a more equitable process for recruiting and retaining physical therapy students who identify as Indigenous. The admissions committee for the UofA has made several changes to their admissions processes. Beginning in the 2017 admissions process, two seats were designated for Indigenous students who meet the requirements for the MScPT program. These changes increase the chances of success for an Indigenous applicant, with the goal of increasing the number of Indigenous physical therapists. Additionally, all applicants to the MScPT program are now required to complete the University of Alberta's Massive Open Online Course (MOOC) Indigenous Canada. Completion of this MOOC ensures students have a baseline understanding of Indigenous histories and contemporary issues so that students can then apply this knowl-

edge throughout their physical therapy training, leading to culturally safe and appropriate physical therapy services.

At UBC, the admissions committee implemented their aboriginal admissions policy in 2017, where four seats were designated for Indigenous students. The number of seats reflects the percentage of Indigenous peoples in British Columbia. Also, an Initiatives for Indigenous Advocacy Committee (IIAC) was formed to help foster advocacy support within the department. The focus of the IIAC is to foster allyship for Indigenous applicants and provide mentorship for Indigenous students in the program. To date, UBC has accepted six Indigenous students, with future goals focusing on recruitment and retention.

The UofM has a long-standing history of targeted efforts at admitting students who self-identify as Indigenous. These efforts have been reflective of the demographics of Manitoba and the historical role of the UofM in the provision of health care services in northern and remote communities, both on- and off-reserve. The first health professional program was established in 1979 in order to facilitate Indigenous student success, both in recruitment and retention. Since 1987, the physical therapy program has admitted over 60 learners who self-identify as Indigenous through a specific admissions category, half of whom have been admitted into the current graduate-level program. Of those individuals, none have self-declared themselves to be of Inuit background, 12% First Nations, and the remainder Métis. Unlike quota approaches, the UofM physical therapy program aims to recruit Indigenous students reflective of the population, currently over 16%. Through an annual diversity survey, this number is known to be an underestimate as some Indigenous individuals choose not to apply through this category. The recent establishment of an Indigenous Advisory Council will work towards further enhancement of recruitment and retention factors.

At the UofS, the MPT program nurtures respect for Indigenous knowledge and culture as core competencies and has been prioritizing recruitment of Indigenous physical therapy students for well over 20 years, with two seats initially reserved in the BScPT program. With the launch of the MPT program in 2007, this increased to five seats (of 40 total seats, or 13%) in order to be more reflective of the population demographic of Saskatchewan. This number was increased to six seats (of 40) in 2014, again, to reflect the population demographic of the province, with 15% of the population identifying as Indigenous. For the past several years, UofS has recruited to, and exceeded, the six seats maintained for Indigenous students. In fact, that has been an increase in the number of qualified applicants who identify as Indigenous, and for the 2017 and 2018 intake, seven and eight, respectively, Indigenous students were recruited into the MPT program. Overall, most of the Indigenous students self-identify as Métis, but diverse First Nation students have enrolled, such as Cree and Dene, with one student identifying as Inuit.

Curriculum

Regular opportunities across physical therapy programs have emerged for students to enhance and apply their knowledge of Indigenous health and culture, increasingly led by Indigenous educators. Examples at the UofA include an Indigenous Health Seminar, which also includes students in occupational therapy (OT) and speech language pathology (SLP). This seminar covers aspects of the history of Indigenous peoples, health disparities, and culturally sensitive ways of working with Indigenous peoples. The UofA physiotherapy students also participate in a seminar on trauma-informed practice and can participate in a clinical elective course, Indigenous Health, where students participate in an interdisciplinary Indigenous Wellness Program for First Nations, Métis, and Inuit people from northern Alberta who have diabetes. The Department of Physical Therapy, in partnership with the other departments in the Faculty of Rehabilitation Medicine, is also in the process of designing an interprofessional Indigenous Health course that will be offered to first year students in the OT, PT, and SLP programs. This will build on content from the Indigenous Canada MOOC and will focus on content related to Indigenous health, system level policies and procedures that impact Indigenous people, as well as case study discussions looking at role clarification for each of the disciplines in managing a variety of patients.

The UBC Centre for Excellence in Indigenous Health founded a program called UBC 23 24 Indigenous Cultural Safety. This program is a required course (four online modules and two in-person workshops) for 13 health professional programs. The in-person workshops are interdisciplinary and cover topics such as Indigenous perspectives of history, the legacy of colonialism in Canada, and Indigenous peoples' health and Canada's health care system. The IIAC in the department of Physical Therapy supported the creation of the course and includes some of the instructors that deliver the in-person workshops. All the in-person workshops are co-facilitated by an Indigenous individual, to support and demonstrate allyship.

At the UofM, the physical therapy program has partnered with the Indigenous Institute of Health and Healing/Ongomiizwin (Clearing a path for generations to come) to deliver Indigenous-led curriculum with the goal of achieving health and wellness of Indigenous Peoples. The recent additions of the Kairos Blanket Exercise (an Indigenous experiential perspective of the history of Canada) and an anti-racism simulation activity for all MPT students have augmented the long-standing tutorials on traditional healing, physiotherapy care on-reserve, and Jordan's Principle.

The UofS MPT program in the School of Rehabilitation continues to expand Indigenous health curricular content throughout the entire 2-year (+6-week) program. In the first year, MPT students engage in classroom learning that highlights the historical context of colonization in Canada and its impact on health and health care today. Anti-racism and anti-oppression educational content is also delivered in the first year of programming. Content is delivered by non-Indigenous allies, as well as Indigenous scholars and community members, and rests upon a foundation of reflective practice throughout. A community health workshop in the core neighbourhood of Saskatoon is delivered at the beginning of second year, providing an experiential context for the social determinants of health and racism in society and the health system. Every year, the program engages in a whole-school professional development activity that has included the Kairos Blanket Exercise and, more recently, a "Power & Privilege" activity. The School has identified Indigenous Health as a strategic priority and has also developed an Indigenous Engagement Working Group, consisting of both Indigenous and non-Indigenous faculty, as one way to exemplify the practice of reconciliation and inform strategic priorities.

Clinical Learning

Physiotherapy learners have long expressed a preference for learning opportunities in the practice environment. In keeping with the Calls to Action of the TRC, physiotherapy programs are working towards focusing more of these clinical opportunities in Indigenous communities by establishing and sustaining meaningful Indigenous partnerships in urban, rural, and remote settings. The UofA Physical Therapy Department continues to explore these opportunities to partner with Indigenous communities for clinical placement experiences in Northern Alberta to better prepare their graduates for working with Indigenous Peoples and in Indigenous communities.

In 2012, 20 of the 80 physical therapy seats at UBC were allocated to the newly developed Northern and Rural Cohort program (NRC). The NRC has a mandate to increase recruitment and retention of physiotherapists to northern and rural regions. The NRC was also able to expand on the type of placements offered and it was at that time that placements with an explicit focus on Indigenous health were created. The NRC partnered with Central Interior Native Health Society (CINHS) to integrate physiotherapy services into the primary care services offered to those of Indigenous descent living on, or close to, the street in Prince George. The NRC has also partnered with Carrier Sekani Family Services in adding a physiotherapist to the primary care team that does outreach to remote First Nations communities. Students accompany the physiotherapist and other members of the

health care team to communities in the CINHS, where services are provided in the local health centre, school, and homes. The Prince Rupert Interprofessional Student-led Model (PRISM) Clinic also offers students the opportunity to travel to remote First Nations communities along the Northwest coast and provide local services and telerehabilitation follow up. These experiences allow students to see the barriers of access to care, as well as the ways in which those can be overcome with innovative service delivery models. Fittingly, we are seeing some of our graduates that were exposed to some of these clinical placement experiences seek employment in these areas upon graduation - coming full circle to address the disparities in health.

The UofM has been sending physiotherapy students for clinical practice opportunities to remote First Nation communities since the late 1980s, and to the Kivalliq Region of Nunavut in the central Arctic starting in 2001. Through recent external funding initiatives, interprofessional practice opportunities have been made available where the focus has been on community partnerships and exposure to Indigenous health and wellness in urban and non-urban communities.

At the UofS, several clinical and experiential learning opportunities have been implemented and are continually being enhanced and expanded. MPT students are supported to engage in volunteer shifts at a student-run clinic (SWITCH) that is in the core neighborhood of Saskatoon, serving a high proportion of individuals who identify as Indigenous. The SWITCH clinic provides MPT students access to an advisory Elder and creates opportunities for MPT students to engage with diverse populations, including First Nation and Métis people. Since 2013, the MPT program at UofS has implemented a practicum in a northern Métis community that has provided experiential learning opportunities for approximately 14 MPT students to live, work, and learn with, and from, Métis community members. Offering clinical placements in rural and remote Indigenous communities throughout Saskatchewan continues to be a challenge, but also a priority. UofS continues to foster relationships with diverse First Nation and Métis communities with the hope and goal of building more clinical practicums that are meaningful and relevant to communities and MPT student learning. The department continues to honour the need for enhanced relationships with First Nation and Métis people in order to better understand ways we can work together and support the creation of culturally safe environments in our health system.

About Robin

Robin Roots is a Senior Instructor at the UBC Department of Physical Therapy in the Faculty of Medicine, and a Coordinator of Clinical Education at the Northern and Rural Cohort (NRC). Her research interests are in health service delivery, in rural and remote regions, and exploring innovative models of service that increase access to care. She has developed a number of clinics and rehabilitation programs across northern BC, including the Prince Rupert Interprofessional Student-Led Model (PRISM) Clinic and the Prince George Cardiac Pulmonary Rehabilitation Program. In the MPT program, she teaches in a number of courses, including topics on rural health, Indigenous cultural safety, e-health, ethics, and qualitative research and quality improvement.

About Lisa

Lisa Jasper is a physiotherapist and faculty member in the Physiotherapy Department at the University of Alberta. She is the Chair of the Admissions Committee for the MScPT program and Coordinator of the Augustana satellite campus of the MScPT program. She teaches in the professional issues curriculum, as well as in chronic pain and business management electives. She is a PhD Candidate in Rehabilitation Sciences with ongoing research in the use of technology in the measurement and promotion of physical activity in older adults.

About Moni

Moni Fricke is a physiotherapist and faculty member in the Department of Physical Therapy at the University of Manitoba. She was Chair of Admissions of the physiotherapy program from 1999 to 2016; the inaugural Medical Rehabilitation Program Coordinator for the Inuit Health Program of the JA Hildes Northern Medical Unit at the UofM; and was awarded her PhD in 2016 where her research focus was the cross cultural validity of disability outcome measures used with First Nations populations. Her current teaching includes professional issues, reflective practice, and interprofessional collaboration.

About Sarah

Sarah Oosman is a first-generation settler Canadian and an ally. She is an Associate Professor in the School of Rehabilitation Science, University of Saskatchewan, and is committed to Indigenous community-driven action research that leads to the co-creation and implementation of culture-based health promoting interventions across the lifespan. Sarah continues to expand her anti-racist and anti-oppression pedagogy in the MPT program, specifically related to professional practice and chronic disease management.

About Peggy

Peggy Proctor is a physiotherapist who identifies as a fourth generation white settler, and also as an ally. She is an advocate for anti-racist and anti-oppressive education, and continuously seeks to understand the legacy of oppression experienced by Indigenous peoples within a white settler society. Peggy was appointed as a clinical faculty member at the University of Saskatchewan in 1998, and she currently serves as Academic Lead Clinical Education & Community Affairs in the School of Rehabilitation Science.

About Simone

Simone Gruenig is a physiotherapist and instructor in the Physical Therapy Department at the University of British Columbia. She is Chair of the Initiatives for Indigenous Advocacy Committee and the primary cardiorespiratory instructor/stream coordinator. She has been a member of the admissions committee for the past ten years and with the department since 2008.

Don't get hooked!

Phishing emails are an ever-present risk

How often do you click on a link sent to you via email? Imagine – you receive an email from a colleague. Their name appears as you would expect, they greet you as they normally would, and they simply ask you to click on a link to something that would be of interest. Would you do it?

It's this kind of simple, subtle tactic that can lead to devastating results for any professional who holds client information if, in fact, that email is not from your colleague. And if you think that you or your business is too small to be targeted by cyber criminals, think again. Small to medium sized businesses are rapidly becoming the hardest hit by this type of risk, especially because many do not invest in robust risk mitigation tools, including technology and insurance.

Quick tip: Before clicking on links or downloading files, check the full email address of the sender. Cyber criminals are becoming more sophisticated, adding legitimate looking email signatures and signing off with the name of a person who actually works with you, which they may have uncovered through trolling social media and business websites. However, the email address is usually where you can verify the sender's credentials. Often it can be just a small detail that can help you recognize whether it's genuine or not. (for example, John.Doe@business.com vs John.DØe@business.com)

A recent industry report highlights that cyber criminals are most active in the health care sector, with health care entities making up 41% of incidents reported. The most significant incidents impacting health care businesses and organizations relate to hacking/malware and unintended disclosure – both accounting for 31% of overall reported health care incidents.*

Insider data breaches within the health care sector were also significantly higher than in other industries and accounted for 17% of all reported health care breaches. Additionally, 8% of reported health care data breaches involved the loss of physical records, 6% were portable device incidents, and 3% were social engineering attacks.

$70,960	133%	31%
Average cost of a business email compromise claim	Increase in business email compromise incidents claim	Losses in the health care sector from accidental disclosure

*https://www.beazley.com/Documents/2019/beazley-breach-briefing-2019.pdf

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What is Malware? Malware is a term used for a malicious piece of software or code that is intended to steal data or credentials, log keystrokes, enable unauthorized access, or otherwise create a risk to the confidentiality, integrity, or availability of data, a network, or other computer resources.

How can you reduce your risk?

How can you reduce your risk?

You don't need to know everything about cyber security to help reduce your risk. Here are some useful tips for PTs and businesses to consider.

Prevent emails from being compromised by taking the following precautions:

- Avoid opening or interacting with suspicious emails – check aspects, such as the full email address of the sender
- Install anti-virus and anti-malware software and ensure they are updated
- Check links before you click (on most browsers, you can see the target URL by hovering over the link)
- Implement multi-factor authentication for remote access
- Provide regular anti-fraud training for employees
- Set up pre-determined codes to confirm requests for employees authorized to request fund transfers
- Limit the number of employees who can authorize wire transfers
- Implement a two- or three-person authentication process for all wire transfers

Apply the following checks if a vendor requests changes to its account details:

- Confirm all requests by a direct call
- Use pre-agreed phone numbers
- Review all requests by a next-level approver before making any changes
- Check that the address or bank account are the same as for previous payments

Even with robust processes and training in place, this area of risk continues to evolve and expand, and incidents can still occur and be costly. Comprehensive Cyber Insurance is being called upon more frequently by individuals and businesses that are impacted by a breach.

Are you Covered?

CPA members have access to a tailored Cyber Security & Privacy Liability Insurance product, underwritten by Beazley Group, a Lloyd's of London insurer and a leading provider with a dedicated in-house team focusing exclusively on helping clients handle data breaches.

Policies start from $90 for individuals and $480 for businesses and provide $1M coverage limits.

What does this insurance protect against? Costs associated with:

- Business interruption
- "Cyber extortion" incidents
- Third party liability for privacy breaches
- First party data protection
- Legal defence in regulatory proceedings related to the violation of a privacy law, including penalties (where insurable)
- Website media content liability & more

CPA members who purchase the Cyber Security & Privacy Liability Insurance also have access to a 24-hour Breach Response hotline.

Do you want to know more?
Visit www.cpa.bmsgroup.com or contact a specialist BMS broker at 1-855-318-6136 or email cpa.insurance@bmsgroup.com

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