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Evaluating Providence Health Care's Cultural Safety Education Initiative for Healthcare Social Workers: Preliminary Results

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Abstract

Purpose: The purpose of this research paper is to evaluate the effectiveness of the Indigenous cultural safety (ICS) workshops run by Providence Health Care (PHC). There is a focus on identifying what confidence and cultural safety are and how they can be obtained in practice with social workers in a healthcare setting. **Methodology:** Three virtual mix-methods surveys were created and administered throughout December 2022 to February 2023. The surveys required participants to self-assess their attitudes, beliefs, knowledge, and skills as they relate to cultural safety in their practice. Survey groups included a control group which completed a one-time survey. Participants of this group did not attend the ICS workshops. The second group included the intervention group who were required to complete a pre-test survey prior to attending an ICS workshop as well as a post-test survey after attendance. The post-test survey included questions about the workshops themselves for further investigation. Quantitative responses were analyzed using an independent t-test (control and intervention responses) and paired t-test (pre-test and post-test responses). Qualitative responses were analyzed using thematic analysis. **Findings:** The independent sample t-test yielded no statistically significant responses between the control and intervention group. The paired t-test yielded significant positive results demonstrating that social workers felt that they had an improved ability to locate services for trauma survivors, recognize and employ trauma-informed practices, and educate colleagues on trauma-informed care post ICS workshops. The post-test specific responses demonstrated that social workers felt that the ICS workshops provided a valuable aspect to their learning as practitioners. The qualitative responses from participants highlighted the success of the ICS workshops, specifically the use of the case vignettes. Opportunities for improvement included prioritizing the safety of the space through less leadership involvement and the desire for the inclusion of the IWR team within the ICS workshops themselves. **Research Limitations:** Confidence and cultural safety require corresponding outcomes based assessments to determine fidelity. Furthermore, the research evaluation occurred simultaneously to the educational initiative ICS workshop roll-out which could have an effect on research sample size and participant satisfaction. **Value of Research:** There are recognized barriers to measuring confidence and the provision of culturally safe care in healthcare settings. This paper adds to the pool of knowledge that social workers do see value in this type of workshop training.

Keywords: Indigenous cultural safety; workplace cultural safety; cultural safety training; healthcare; social work

The conclusions, interpretations and views expressed in these articles belong to the author(s) as individuals and may not represent the ultimate position of the Ministry of Children and Family Development.



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Introduction

In 2015, Providence Health Care (PHC) signed a Declaration of Commitment to Cultural Safety and Humility in recognition of its duty to act upon the recommendations laid out by the Truth and Reconciliation Commission of Canada's Calls to Action (2015). In 2019, British Columbia's provincial government passed the Declaration on the Rights of Indigenous Peoples Act (DRIPA), establishing a framework for reconciliation (Horgan et al., 2022). Considering the findings and recommendations highlighted by the In Plain Sight report (Turpel-Lafond, 2020), health organizations are urgently seeking ways to address Indigenous-specific racism and cultural safety within their institutions. With the phasing out of the San'yas training, PHC social work leadership team took a new direction with input from the Indigenous Social Worker and Cultural Safety Consultant, and created their own cultural safety educational initiative with ongoing input from the Indigenous Wellness and Reconciliation team at PHC. The goal of our research was to conduct an evaluation of PHC's educational initiative by conducting a literature review and by obtaining mixed-methods data from the participants themselves. In gathering this data, the team sought to answer the following research question: "does the educational initiative enhance healthcare social worker's confidence in being able to practice culturally safe care when working with Indigenous service users in a hospital setting?"

Literature Review

Theoretical Framework

Albert Bandura, creator of Social Learning theory, stated that "cognitive processes play a prominent role in the acquisition and retention of new behavior patterns" (1977, p. 192). Bandura saw learning on a trajectory which moves from observation to performance to performance feedback and adjustment (1977). Successful performance, as Bandura postulated, comes from the interaction between environmental feedback as well as the internal feedback of the performer (1977). With an educational training initiative, supported learning with the goal of sustained behavior change are essential. For our research, we

used social learning theory and the work of Bandura (1977) to inform our interpretations of the educational initiative and the data retrieved.

Confidence

Confidence is described by Bandura (1977) as a "conviction that one can successfully execute [a desired] behavior required to produce the [desired] outcomes" (p. 193). Confidence exists on a spectrum, and unlike self-esteem or self-concept, it can vary based on task and situational conditions (Bandura, 2012, as cited by Kane et al., 2021; Stankov & Lee, 2008; Zimmerman, 2000). Confidence influences academic motivation and capacity (Bogo et al., 2017; Zimmerman, 2000). For this reason, educators find the role and acquisition of confidence pertinent. Those with higher confidence levels "participate more readily, work harder, persist longer, and have fewer adverse emotional reactions when encountering difficulties" (Bandura, 1997, as cited by Zimmerman, 2000). High-confidence social workers can maintain focus with clients and interpret their anxiety as challenging rather than overwhelming and hindering (Bogo et al., 2017; Regher et al., 2010). That said, confidence levels must be appropriately matched with one's knowledge and capabilities to ensure an accurate understanding of the complexity of the tasks and safe patient care (Holden et al., 2002; Baxter & Norman, 2011).

The relationship between learning and confidence is complex, as the acquisition of learning and confidence can happen at different rates (Bandura, 1977; Baxter & Norman, 2011). This relationship was indicated as one of the limitations of the San'yas training model, noting that learning does not necessarily change someone's behavior (First Nations Health Authority, Province of British Columbia & Indigenous Services Canada, 2019). Bandura's (1977) framework for confidence acquisition notes that there are four commonly used models used in training: Emotional arousal, verbal persuasion, vicarious experience, and performance accomplishments. Although each model offered by Bandura (1977) varies based on intensity, they all include an aspect of emotional awareness and emotional regulation, factors highlighted as significant in broader research (Bogo et al., 2017; Regher et al., 2010; Vagni et al., 2020). As indicated by Regher et al.

(2010) in their study of child welfare workers, high confidence levels were attributed to training, past supervision, and experience. Therefore, in addition to knowledge provision, emotional awareness and regulation can facilitate confidence in concert with comprehensive and sustained teachings.

Educators and researchers continue to seek ways to measure confidence as a way of enhancing learning and performance; however, confidence in performance and performance outcomes are different (Baxter & Norman, 2011; Holden, 2002). The validity of self-assessments in accurately measuring confidence is controversial. Baxter and Norman (2011), in their one-group pre-test post-test study with nursing students, found that all but one of the sixteen correlations between self-assessment and the observed clinical examination were negative. Other researchers conclude that confidence self-assessments are ideal for social work educational outcome assessments if used in addition to a retroactive pre-test-post-test design to account for possible response shift bias (Holden et al., 2002). As Bandura (1977) suggests, differences between confidence and performance outcomes may arise when situational, and task factors are ambiguous and advise that participants understand what kind of behavior is expected and under what circumstances. Teaching and learning styles may also account for the differences in confidence self-assessments and performance outcomes. Finally, confidence and learning are reciprocal and built over time using repetition and self-regulation strategies (Bandura, 1977; Bogo et al., 2017). As such, research measuring confidence and outcome expectations will need to attune to the reality of this relationship.

Cultural Continuum

The cultural continuum depicts the image of an arrow going from cultural awareness to cultural sensitivity, cultural competency, and cultural safety. Brascoupé and Waters (2009) state that visualizing the continuum clarifies where cultural safety is situated to compare to compare the negative and positive approaches. Each stage on the continuum represents "steps in the process of attuning government to the people it governs, and institutions and individuals to the people they serve" (Brascoupé & Waters, 2009, p. 8). On

the positive end of the continuum, Dell et al. (2015) share that the cultural continuum is often perceived as knowledge, attitude, and behavior that begin with cultural awareness and develop into cultural safety for Indigenous service users. The literature acknowledges this linear progression but also that becoming culturally safe is a paradigm shift that requires service providers to reflect on themselves critically (Brascoupé & Waters, 2009; Curtis et al., 2019; Yeung, 2016). The paradigm shift refocuses the knowledge-based cultural competency approach and repositions cultural safety as a power transfer (Brascoupé & Waters, 2009). The positive end of the continuum starts with awareness and recognition of Indigenous cultures, then integrating and implementing the acquired knowledge (Brascoupé & Waters, 2009; Yeung, 2016). As the continuum progresses, further education is required to understand the services delivered to Indigenous service users. While the service provider's knowledge is measured by cultural competency, cultural safety shifts the power to the service user to instruct and share their knowledge and practices with the service provider (Brascoupé & Waters, 2009; Yeung, 2016). This shift repositions the service user from being a passive recipient to someone with power in the relationship. In summary, cultural safety places the onus on the service provider to focus on understanding oneself and internal biases by implementing reflexive practice and allowing patients to determine whether their interactions are safe.

Cultural Safety and Trauma Informed Practice

The Métis Centre of the National Aboriginal Health Organization (MCNAHO) argues for the advantages of cultural safety by contrasting it along the cultural safety continuum (2013). MCMAHON describes the leading proponent of cultural safety as an understanding of how service providers position themselves in power dynamics and reflect upon their values (2013). The principles stated by the MCNAHO demonstrate progress towards understanding how to apply and use cultural safety and, notably, acknowledging power imbalances. Moreover, the MCNAHO (2013) emphasizes the need for systems and individuals to cultivate safe cultural practices. Therefore, the MCNAHO focus on systems, institutions, and organizations being culturally safe. MCNAHO outlines the provision of training and ongoing

development of cultural safety skills with the support of Indigenous community members, which should be followed up with self-assessments and reflections (2013). Instead of solely relying on individual practitioners, practitioners can shift away from deciding whether their cultural practices are safe and hold space for patients to express their needs.

As previously stated, cultural safety requires individuals to reflect on their beliefs to change personal beliefs and values. In order to further advance cultural safety, a trauma-informed practice (TIP) is also essential to consider. TIP aims to change systems by supporting care providers in understanding how service users are affected by traumatic stress (Bryson & Bosma, 2018; Tujague & Ryan, 2021). In order to successfully use TIP, service providers prioritize safety, choice, and control by accommodating physical and emotional safety through healthy interactions with service users (Harris & Fallot, 2001, as cited by Bryson & Bosma, 2018; Tujague & Ryan, 2021). TIP can prevent physical and emotional safety by prioritizing a safe space (Mkandawire-Valhmu, 2018). Bryson et al. (2017), as cited by Bryson and Bosma (2018), also note that the implementation of TIP has positive results in "patient symptomatology, patient and staff injuries, episodes of seclusion and restraint, and staff morale."

Measuring Cultural Safety

Measuring cultural safety proves challenging as being culturally safe has yet to be quantified. West et al. (2021) aimed to create a tool to measure cultural safety attributed to the growth of cultural safety education in the curriculum. The Ganngaleh nga Yagaleh (GY) tool used in this research consists of forty-one questions emphasizing reflection and advocacy. The GY tool was created using decolonizing principles (Lock, 2018, as cited by West et al., 2021) as it utilized the "process of truth-telling in education and training" (Aphra, 2019; Krathwohl, 2002; Ramsden, 2002; as cited by West et al., 2001, p. 350). Co-creating evidence to support dialogue around indicators for change should be mandatory in cultural safety curricula, education, and training for service providers and students. The authors discuss the value of collaborating with Indigenous service users to promote best practices in education and support developing education on health inequities.

Elvidge et al. (2020) identified a gap in critical indicators and empirical cultural safety measures from a service user's perspective. Consequently, creating an assessment survey tool to assess healthcare practitioners' cultural safety from the perspective of Indigenous service users. The domain of Elvidge et al.'s (2020) survey calls attention to communication, trust, environment, and support of cultural values. It is important to note that even though practitioners may self-report as being culturally safe, the service user will ultimately identify if they are feeling safe. As West et al. (2021, p. 366) highlighted, "culturally safe healthcare practice requires a commitment to ongoing learning and unlearning, critical reflection and evaluation, which in turn requires the development of skills and knowledge and changes in attitudes and behaviors."

Methodology

Ethics

The student researchers completed a Full Behavioural Research Ethics Board (BREB) application as required by the UBC on behalf of the research team. The BREB application included the research team's poster, participant consent form, survey questions, Covid-19 requirements, safe research plan, and the student researchers Tri-Council Policy Statement (TCPS) 2: Core 2022 certificates of completion. The BREB application was approved by the UBC and the research team was given permission to conduct the research project.

Sampling Frame

PHC employs roughly one hundred and twenty regular and a small pool of casual social work staff. Purposive sampling was used to target this population. Purposive sampling is ideal for selecting cases that are illustrative of a phenomenon, for selecting difficult to reach members of a unique population, or for identifying particular types for investigation in greater detail. Social workers are the ideal population to sample as they are primed for self-reflection and are often willing to contribute to research if it contributes to better practice or social justice.

Recruitment and Inclusion/Exclusion Criteria

Recruitment occurred virtually through virtual posters from December 2022 to February 2023. Virtual posters were distributed bi-monthly by the research sponsor.

For the purpose of program evaluation, our exclusion criteria was initially limited to social workers, however that criteria was expanded to include social work assistants to ensure a large sample size. As our sample was limited to social workers and social work assistants employed by PHC, most of our exclusion criteria was accounted for; all PHC social workers must be registered with the British Columbia College of Social Workers and fluent in English. To ensure that the responses from social workers and social work assistants were being utilized in our data analysis exclusively, workshop attendance lists were cross referenced.

Analysis

The student researchers drafted pre-test survey and post-test survey questions based on the Multicultural Practice Competencies Tool (Alberta Health Services, 1996) and the Addressing Racism questionnaire (Government of B.C., 2020). In collaboration with the research sponsors, the Director of Indigenous Cultural Development, and PHC's Indigenous Wellness and Reconciliation (IWR) team, the survey questions were reviewed, revised, and confirmed. The research surveys included eighteen questions assessing various aspects of trauma-informed care knowledge and skills among social workers at Providence Healthcare. The post-test survey included the provision of seven additional questions aimed at assessing the ICS workshops themselves. In addition to a pre-test survey and post-test survey, the research team decided to include the option of participating in a control survey. The control survey did not require that participants attend an educational workshop rather, they could solely participate in the research by completing a one-time response. Once solidified the control, pre-test, and post-test surveys were transferred to UBC Qualtrics for virtual completion as appropriate.

Quantitative

SPSS, a data analysis software, was utilized to analyze the quantitative data obtained from the Likert-scale questions in the survey. Inferential statistics such as t-tests were used to compare mean scores between groups and determine statistical significance. The statistical analysis method used to analyze the data was a paired t-test and independent t-test. A paired t-test

was used to compare the means of two related groups (in this case, pre-test and post-test survey responses from the same participants), while an independent t-test was used to compare the means of two unrelated groups (control group and the intervention group). These tests were used to determine differences between the responses and groups with the goal of highlighting any statistical differences.

To analyze the Likert-scale data, descriptive statistics were calculated by SPSS to determine the mean, standard deviation, and p-value of participants' responses. A 95% confidence interval was used to determine the significance of our results, with a predetermined significance threshold of 0.05 for statistical significance and 0.1 for approaching significance. If the p-value from our statistical test was less than 0.05, we considered the result statistically significant. If the p-value was greater than or equal to 0.05 but less than 0.1, we considered the result to be approaching significance. All quantitative results, regardless of significance, were included in Tables 1-5 (see Appendices) for examination.

Qualitative

Qualitative data from survey comments were coded and categorized to identify themes or patterns. The comments were read and assigned codes to different portions of the text that relate to similar themes or concepts. After the coding was complete, the data was analyzed to identify patterns or themes that emerge across the comments. All qualitative results were included in Table 6 (see Appendices) and sorted under the appropriate codes, themes, and subthemes for examination. The goal of the analysis was to identify the most salient themes or patterns in the data, and to use these insights to better understand the experiences and perspectives of the participants.

Results

Participants

From December 2022 to February 2023, two ICS workshops were run. During this time, the option for completing a control survey exclusively was also advertised. The first workshop yielded five completed pre-test survey and post-test survey responses from participants. Another four participants completed the

post-test survey only and one participant completed the pre-test survey only. The second workshop yielded five completed pre-test survey and post-test survey responses from participants. Another four participants completed the pre-test survey only. The control group initially yielded three responses; however, given the five responses from the pre-test surveys that did not have a completed post-test survey, we merged these with the control group bringing the total number of control group responses to eight. Similarly, with the four responses that were post-test survey responses exclusively, we merged these with the intervention group bringing the total number of intervention responses to fourteen.

Table 1. Participant Demographics (N = 19)

Participant demographics (N = 19)			Control ^c		Intervention ^d	
	n	%	n	%	n	%
Gender						
Male	1	5.2	0	0.0	1	5.2
Female	15	78.9	8	42.1	7	36.8
Missing	3	15.7	0	0.0	3	15.7
Total	19	100	8	42.1	11	57.7
Ethnic-Cultural Identity						
Asian	5	26.3	3	15.7	3	15.7
White	9	47.3	4	21.0	5	26.3
Mixed ethnicity	1	5.2	1	5.2	1	5.2
Prefer not to answer	1	5.2	0	0.0	0	0.0
Missing	3	15.7	0	0.0	2	10.5
Total	19	100	8	41.9	11	57.7
Years working at PHC						
0-10	12	63.1	5	26.3	7	36.8
11-20	4	21.0	3	15.7	1	5.2
Missing	3	15.7	0	0.0	3	15.7
Total	19	100	8	42.0	11	57.7
Professional Title^a						
Social Worker ^b	16	84.1	7	36.7	9	47.3
Social Work Assistant	2	10.5	0	0.0	2	10.5
Other	1	5.2	0	0.0	1	5.2
Total	19	100	7	36.7	12	63.0

^a This data was not collected prior to ICS Workshop 2

^b In workshop 1 this data was not collected, however it was verified with PHC site lead that they have MSW degree and therefore in a social worker role

^c This group contains participants who completed a one-time survey and who did not complete a cultural safety workshop and participants who completed a pre-test survey, but did not complete a post-test survey

^d This group contains participants who completed both a pre-test and post-test survey and participants who only completed a post-test survey after attending a workshop

Table 2. Racism 1 (N = 18)

Independent Sample T-test Control v. Intervention

Question	Control n	Control ^c M (SD)	Intervention n	Intervention ^b M (SD)	t	p
1. Witnessing racism ^a	8	1.50 (.756)	8	2.20 (.789)	-1.905	.075
2. Systemic and organizational racism ^b	10	3.38 (1.118)	10	3.20 (.789)	.375	.712

^a Likert Scale: Yes (1), No (2), Not Sure (3)

^b Likert Scale: Extremely Prevalent (1), Very Prevalent (2), Somewhat Prevalent (3), Non Existent (4), Not Sure (5)

^c This group contains participants who completed a one-time survey and who did not complete a cultural safety workshop and participants who completed a pre-test survey, but did not complete a post-test survey

^d This group contains participants who completed both a pre-test and post-test survey and participants who only completed a post-test survey after attending a workshop

Paired Sample T-test Analysis

Of the eighteen survey questions posed, three showed significant differences between pre- and post-test scores. These questions were related to the ability to locate services for trauma survivors, recognizing and employing trauma-informed practices, and educating colleagues on trauma-informed care. The significant improvements in scores for these three questions indicate that the training program was effective in improving participants' knowledge and skills in these specific areas of trauma-informed care.

Specifically, participants' ability to recognize and employ trauma-informed practices showed a significant increase from pre-test (M = 2.33, SD = 0.707) to post-test (M = 2.89, SD = 0.601), $t(19) = -3.162$, $p = .013$. Similarly, their ability to educate colleagues about

Table 3. Pre-test (N = 8) Post-test (N = 9)

Paired Sample T-test (N = 9) Pre-test v. Post-test scores

Question	Pre (N= 9) M (SD)	Post (N= 9) M (SD)	t	p	Cohen's d
1. Personal cultural identity	2.56 (.882)	2.89 (.601)	-2.000	.081	-.667
2. Beliefs and values around health and wellness	2.67 (.707)	3.11 (.601)	-1.835	.104	-.612
3. Recognizing varying definitions of family, cultural experiences and perspectives	3.00 (.866)	3.22 (.972)	-1.000	.347	-.333
4. Articulating of privilege and social location	3.00 (1.000)	3.22 (.833)	-1.000	.347	-.333
5. Openness to feedback and willingness to change	3.22 (.667)	3.11 (.601)	.555	.594	.185
6. Triggering impact of social location	2.67 (.707)	2.78 (.667)	-1.000	.347	-.333
7. Recognizing Indigenous cultural diversity and ongoing learning	3.56 (.882)	3.33 (.866)	1.512	.169	.504
8. Identifying of ongoing colonial impact	2.78 (.833)	2.89 (.601)	-.555	.594	-.185
9. Ability to find culturally safe research and education	2.22 (.667)	2.11 (.333)	.555	.594	.185
10. Recognizing the strength of knowledge integration	2.89 (1.054)	2.89 (.782)	.000	1.000	.000
11. Articulating findings and recommendations of <i>In Plain Sight</i> report	1.78 (.441)	2.11 (.601)	-2.000	.081	-.667
12. Describing institutional barriers within my organization	2.44 (.527)	2.78 (.667)	-2.000	.081	-.667
13. Recognizing organizational influences on personal values	2.56 (.527)	2.67 (.500)	-1.000	.347	-.333
14. Educating colleagues on differing cultural practices and needs	1.89 (.782)	2.33 (.707)	-2.530	.035	-.843
15. Ability to locate Indigenous specific resources	2.44 (.726)	2.78 (.833)	-1.414	.195	-.471
16. Recognizing and employing trauma-informed practices	2.33 (.707)	2.89 (.601)	-3.162	.013	-1.054
17. Recognizing incidents of unfair systemic and interpersonal treatment ^a	2.38 (1.054)	2.50 (.972)	-1.000	.351	-.333
18. Ability to locate services to support spiritual needs and wellness ^a	1.88 (.866)	2.38 (.500)	-2.828	.033	-.943

Likert Scale: 4 (Very well), 3 (Well), 2 (Somewhat), 1 (Not at all)

^a Sample size adjusted by removing participant who answered "prefer not to answer".

trauma-informed practices showed a significant increase from pre-test ($M = 1.89$, $SD = 0.782$) to post-test ($M = 2.33$, $SD = 0.707$), $t(19) = -2.530$, $p = .020$. Finally, their ability to locate services for individuals who have experienced trauma also showed a significant increase from pre-test ($M = 1.88$, $SD = 0.866$) to post-test ($M = 2.38$, $SD = 0.500$, adjusted for one participant who chose not to answer), $t(18) = -2.828$, $p = .033$.

Independent Sample T-Test Analysis

The results of the independent sample t-test analysis yielded no statistically significant results between the control group and the intervention group (refer to Appendix).

Post-Test Survey Data Analysis

The results of the post-test survey specific questions revealed that participants who completed the post-test surveys thought the case vignettes were effective (92.9%) and realistic (100%), the workshop met their learning needs (92.9%), and that the workshop enhanced their ability to practice culturally safe care when working with Indigenous service users, families, and communities (92.9%). Participants stated that the timing of the workshop worked within their schedule (78.6%), they were able to access protected time to attend the workshop (78.6%), and that they would participate in more ICS workshops (100%).

Qualitative Data Analysis

The results of the qualitative data gleaned from the surveys revealed 6 codes, 8 themes, and 4 sub-themes. The first code generated by the data was workshop reflections which was then divided into workshop successes (WS) and workshop challenges (WC). Workshop successes (WS) were reported more frequently (7), with workshop challenges (WC) being reported less frequently (3). The second code generated by the data was Indigenous inclusion which was then divided into Indigenous inclusion sufficient (IIS) and Indigenous inclusion not sufficient (IINS). These themes came up equally at two responses each. The third code generated by the data was safety of space which was then divided into safe space (SS) and safety challenge (SC). Safe space (SC) was reported more frequently (6), with safety challenges (SC) reported less frequently (2). The fourth code generated by the data was format which was then divided into format successes (FS) and

format challenges (FC). Format challenges (FC) were reported more frequently (3), with format successes (FS) reported less frequently (1). The fifth code generated by the data was content which was then divided into content successes (CS) and content challenges (CC). Content successes (CS) were reported more frequently (12), with content challenges (CC) reported less frequently (4).

Discussion

The significant results from the paired sample t-test demonstrate that social workers themselves believe that their confidence to practice culturally safe care when working with Indigenous service users has increased thus, the hypothesis has been supported in the following areas: feeling equipped to educate colleagues, identifying and employing trauma-informed practices, and locating services to that support the spiritual needs and wellness of service users. From the independent sample t-test, no significant data was obtained between the control and intervention groups thus, a null hypothesis was determined. The present study adds to the current body of literature demonstrating that a brief, workshop-style intervention can have significant and positive impacts on healthcare social workers' confidence levels.

Interestingly however, patterns emerged from the non-significant findings of the t-tests demonstrating that the results could be bi-directional. In the paired sample t-test, participants reported lower scores when reporting on openness to feedback and willingness to change, the recognition of Indigenous cultural diversity and the need for ongoing learning, and their confidence in the ability to find culturally safe research and education (refer to Table 3 on the previous page). In the independent sample t-test, participants frequently reported lower scores in the intervention group (refer to Appendix).

The findings in the paired sample t-test and independent sample t-test are supported by the research in the literature review as it suggests that confidence self-assessments have yielded mixed results. Holden et al. (2002) warned against response shift bias and urged researchers to use a retroactive pre-test-post-test design to account for this. As our pre-test and

post-test study design did not utilize this method, it is possible that response shift bias was a factor in the responses.

This study builds upon the literature reviewed by Curtis et al. (2019), Johnstone and Kanitsaki (2007), and Brascoupe and Waters (2009) by demonstrating that a brief, workshop-style intervention can have significant and positive impacts on healthcare social workers' confidence levels in practicing cultural safety. However, the findings also suggest that participants reported lower scores on aspects related to cultural safety, such as openness to feedback, willingness to change, and recognition of Indigenous cultural diversity, which is consistent with Dell et al. (2016) and Elvidge et al. (2020) who highlight the importance of understanding and addressing cultural safety in healthcare settings. Moreover, Ryder et al. (2019) and West et al. (2021) emphasize the need for effective cultural safety education to ensure Indigenous patients receive equitable and culturally safe care.

The qualitative data from the workshop evaluations revealed several key themes related to the success and challenges of the workshop. First, the feedback on the workshop's format was mixed, with some participants noting the convenience of the online Zoom format. In contrast, others preferred in-person sessions for better engagement and focus. One participant commented, "although Zoom is more practical, nothing beats in-person - I find I'm more focused and engaged in person." Despite this, the case study format received overwhelmingly positive feedback, with participants appreciating the opportunity for open-ended discussions around realistic and challenging scenarios. One participant stated, "I like how it was open-ended with no definite answer as all situations will require diverse thinking and accommodating."

Another theme that emerged from the qualitative data was related to the safety of the space provided during the workshop. Participants felt that the space was non-judgmental and safe for discussing cultural safety. One participant noted, "it felt like a very non-judgmental space to be vulnerable and discuss the practice and knowledge areas that we are lacking." However, some participants expressed concerns about the presence of leadership and supervision during the

discussions, potentially discouraging free and anonymous sharing.

The theme of Indigenous inclusion emerged in the qualitative data, with some participants expressing positive feedback about the inclusion of Indigenous perspectives and voices in the workshop and others reporting not enough. For example, one participant stated, "I liked that there were Indigenous people in the group that shared their views." while another stated "I would have liked to have heard more from the Indigenous participants rather than facilitators". Although this would need to be explored further, it could be postulated that the participants had the expectation that Indigenous participants should be participating more which means that they would be contributing more emotional labor than necessary. At the same time, another participant appreciated the insight and wisdom shared by staff from the IWR team, an appropriate expectation given the formal role of the team members.

Overall, the qualitative data from the workshop evaluations highlighted successes and challenges of the workshop format, content, and inclusion efforts. The themes that emerged from the data suggest that while participants appreciated the open-ended case study format and safe space for discussion, further efforts could be made to improve Indigenous appropriate inclusion through the use of the IWR team and further anonymity in discussions.

Limitations

With confidence and cultural safety outcomes, the literature advises us that self-assessment scores may not equal outcome scores. Notably, this was one of the limitations of the San'yas training model as participant learning may not have an impact on the outcome (First Nations Health Authority, Province of British Columbia & Indigenous Services Canada, 2019). Learning and outcome discrepancies were found in Baxter and Norman's (2011) study as all but one of the sixteen correlations between self-assessment and the observed clinical examination were found to be negative. According to Bandura (1977), the educational ICS workshops would be typed as verbal persuasion. From this perspective, verbal persuasion type training does not account for the disruption that may come with the

stress of the situation itself. It is for this reason that the incorporation of self-regulation strategies were advised (Bogo et al., 2017; Regher et al., 2010; Vagni et al., 2020), but not included in the educational ICS workshops themselves as focus remained on the case vignettes. The literature on cultural safety further enforces this as culturally safe care can only be determined by the service user, not the provider (Brascoupé & Waters, 2009; Yeung, 2016).

The literature advises us that confidence and learning are built over time (Bandura, 1977). As our research was only able to gain participation responses from two ICS workshops, this is a limitation for this report in particular as our data would ideally be able to follow the social workers over time for further assessment.

As with the roll-out of any new educational initiative, our results may include commonly encountered issues with a newly developing training. The research evaluation took place synchronously with the workshop rollout which may have contributed to confusion about the research surveys themselves or accounted for a smaller research sample.

Finally, as our target research participants were to attend the ICS workshops and complete the research surveys during work time, this could have been a limiting factor. Incomplete pre-test and post-test survey responses also support this statement as there were a number of pre-test surveys and post-test surveys exclusively. Furthermore, the participation in both the ICS workshops and research was voluntary. Participants that may have benefitted from the ICS workshops the most and thus could have elicited interesting findings, may not have been captured in the data.

Recommendations

Based on the findings of this research project, it is recommended that cultural safety education continue to be included in social work healthcare education and training curriculum. Policies and guidelines should be reviewed during supervision or protected time to ensure that cultural safety and Indigenous health perspectives are included. This should include extending cultural safety training to include all healthcare providers which contributes to the goal of working towards reconciliation in healthcare.

The inclusion of cultural safety education in healthcare training has the potential to improve the quality of care for Indigenous service users, their families, and their communities. By incorporating cultural safety education into healthcare training, providers can better understand the context of health disparities and provide more culturally safe care to Indigenous service users. Additionally, incorporating cultural safety principles into clinical practice guidelines can help healthcare providers to identify and address the unique health needs of Indigenous patients, and promote a more respectful and collaborative relationship between healthcare providers and Indigenous communities.

With the literature on confidence in mind, the introduction of retroactive pre-test and post-test surveys could prove useful in combating possible response shift bias. Additionally, the introduction of mindfulness strategies along with further opportunities to practice skills during role play is advisable.

With the literature on cultural safety and trauma-informed care several recommendations can be made. First, conducting longitudinal studies can be valuable in examining the effectiveness of such practices over time, including measuring outcomes such as improved mental health and wellbeing, increased access to services, and decreased disparities. Second, qualitative studies can help to better understand the experiences of both individuals who have received cultural safety and trauma-informed care, as well as practitioners who provide such care. Qualitative studies can help identify factors contributing to successful outcomes and areas where improvements could be made, which also provides time for practitioners to reflect on their practice. Lastly, collaborative research efforts between researchers, practitioners, and community members should continue to be encouraged to ensure that research is informed by the needs and perspectives of those most affected by cultural safety and trauma-informed care.

Future Directions

In late 2022 a Cultural Safety and Humility Standard (CSHS) for First Nations in British Columbia (BC) was created (Health Standards Organization, 2023). This

accreditation standard for achieving cultural safety and humility was called for in the In Plain Sight report and marks a significant milestone event along the path toward ending Indigenous-specific racism in BC's healthcare system (Health Standards Organization, 2023). The Standard itself was driven by a First Nations-led technical committee, supported by the FNHA, with input from Métis Nation BC and in partnership with Health Standards Organization (HSO) (Health Standards Organization, 2023). PHC social work leadership recognizes that this will change how cultural safety is measured in B.C. and is anticipating that needed changes will accompany the integration of this standard with PHC in the future.

Finally, as the educational initiatives and the research evaluation will continue throughout 2023, new insights will be gathered. Information that was gathered within our evaluation will be expanded upon for a more nuanced understanding or nullified over time. The educational initiative will see changes that occur both naturally and intentionally as the research will inform practice.

Conclusion

This research project explored the effectiveness of cultural safety education and trauma-informed care in improving healthcare outcomes for Indigenous service users. Through a mixed-methods approach, the study found that cultural safety education can improve healthcare social worker's confidence at providing culturally safe care when working with Indigenous service users, their families, and their communities.

The findings of this study support the importance of cultural safety education and trauma-informed care in healthcare training and clinical practice guidelines. Including these principles can help healthcare social workers better understand the context of health disparities to respond reflexively and provide more culturally safe care. Furthermore, incorporating cultural safety principles into clinical practice guidelines can support healthcare social workers to identify and address Indigenous service users' unique health needs by promoting a more respectful and collaborative relationship between healthcare social workers.

Based on the findings of this study, it is recommended that cultural safety continue to be included in social work healthcare education and training curricula. Policies and guidelines should be reviewed during supervision or protected time to ensure that cultural safety and Indigenous health perspectives are included. Additionally, the introduction of retroactive pre-test and post-test surveys could prove useful in combating possible response shift bias, mindfulness strategies, and further opportunities to practice skills during role play.

Future directions for research and practice include conducting longitudinal studies to examine the effectiveness of cultural safety and trauma-informed care over time and qualitative studies to better understand the experiences of both service users and healthcare providers. Collaboration between researchers, practitioners, and community members is encouraged to ensure that research is informed by the needs and perspectives of those most affected by cultural safety and trauma-informed care.

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Appendices

Table 4. Control (n = 8) Intervention (n = 14)

Independent Sample T-test (N = 18) Control Tests v. Intervention Tests

Question	Control M (SD)	Intervention M (SD)	t	p
1. Personal cultural identity ^a	3.00 (.577)	2.79 (.579)	.800	.433
2. Beliefs and values around health and wellness	2.75(.463)	3.07 (.616)	-1.279	.215
3. Recognizing varying definitions of family, cultural experiences and perspectives	3.00 (.756)	3.29(.825)	-.804	.431
4. Articulating of privilege and social location	3.38 (.744)	3.36 (.745)	.054	.957
5. Openness to feedback and willingness to change	3.50 (.535)	3.29 (.726)	.727	.476
6. Triggering impact of social location	3.00 (1.069)	2.71 (.726)	.748	.463
7. Recognizing Indigenous cultural diversity and ongoing learning	3.88 (.354)	3.43 (.756)	1.563	.134
8. Identifying of ongoing colonial impact	3.25 (.886)	2.93 (.616)	1.004	.327
9. Ability to find culturally safe research and education	2.75 (.886)	2.21 (.426)	1.928	.068
10. Recognizing the strength of knowledge integration	3.38 (.744)	3.00 (.784)	1.098	.285
11. Articulating findings and recommendations of <i>In Plain Sight</i> report	1.88 (.991)	2.00(.877)	-.307	.762
12. Describing institutional barriers within my organization	2.75 (1.035)	2.79 (.699)	-.097	.924
13. Recognizing organizational influences on personal values	3.25 (.707)	3.00 (.679)	.818	.423
14. Educating colleagues on differing cultural practices and needs	2.38 (.744)	2.57 (.756)	-.590	.562
15. Ability to locate Indigenous specific resources	2.88 (.835)	2.64 (.745)	.674	.508
16. Recognizing and employing trauma-informed practices	3.00 (.926)	2.93 (.616)	.218	.830
17. Recognizing incidents of unfair systemic and interpersonal treatment ^a	2.63 (.744)	2.69 (.480)	-.253	.803
18. Ability to locate services to support spiritual needs and wellness	2.88 (.641)	2.43 (.514)	1.794	.088

Table 5.
Post-Test Specific Questions (n = 18)

Question	n	Yes		No	
		n	%	n	%
1. Do you think case vignettes are an effective training modality for enhancing cultural safety for healthcare?	14	13	92.9	1	7.1
2. Were the case vignettes realistic?	14	14	100.0	0	0
3. Did the ICS Workshop meet your expected learning needs?	14	13	92.9	1	7.1
4. Do you think the overall workshop enhanced your ability to practice cultural safety with Indigenous clients, families, and communities?	14	13	92.9	1	7.1
5. Did the timing of the ICS workshop work with your schedule?	14	11	78.6	3	21.4
6. Do you plan on participating in more PHC's ICS workshops?	14	14	100.0	0	0
7. I can access protected time to participate in professional development specific training and education without being pressured to return to work	14	11	78.6	3	21.4