RURAL AND NORTHERN SOCIAL WORK PRACTICE 2E: EXAMPLES WITHIN A CANADIAN CONTEXT



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Anti-Oppressive Practice in Rural/Small Indigenous Communities: An Intersectional and Trauma-Informed Approach to Decolonial Praxis

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Denica Dione Bleau

Fundamental to anti-oppressive social work praxis—the act of enacting, implementing or applying a form of practice—within Indigenous communities is to incorporate and implement a decolonized, trauma-informed, and culturally-safe framework. At the core of these frameworks are relationality and relational accountability. Throughout this chapter I will speak to praxis, rather than practice, as praxis is the intentional enactment of the frameworks (practice). An essential foundation of a dynamic social work praxis is to build relationships within Indigenous communities and with community members, while valuing and implementing the knowledge systems and values therein. As Indigenous or non-Indigenous social workers, the social work profession must examine how it has been colonially developed, and often maintains settler-colonial policy and practices; this approach devalues Indigenous sacredness of relationships. Comprehension of the historical manifestation of social work is imperative to prevent perpetuating colonial harm, alongside understanding the effects of colonization in rural and remote Indigenous communities. The views shared throughout this chapter must not be interpreted as a concrete blueprint for working within these communities, but rather, to underscore the importance of relationality with community and community members in social work practice.

The purpose of this chapter is to critically examine the history of social work in its relation to settler-colonial policies, to understand how our individual education, beliefs and worldviews may be informed by settler colonialism. While evaluating history, structures, and policies, we can critically examine our roles as social workers within rural and remote Indigenous communities, strive to develop meaningful relationships, and to integrate and establish our roles as helpers or co-creators, rather than as saviours.

The discussion of social work history and current policies can produce feelings of shame and discomfort. It is important to acknowledge these feelings, while working to understand the roots of these feelings, rather than resorting to offence and/or disregard. It is through this personal work that social workers can become co-creators, helpers, and allies.

The first part of this chapter will examine the history of settler colonialism and its roots within social work practice. Examining the roots of social work will provide context to understanding current and intergenerational trauma within Indigenous communities. Next, social work praxis will be explained through the importance of enacting an anti-oppressive practice, building relationships within community, cultural safety, decolonial praxis, and trauma-informed practice. The chapter will conclude with an explanation service delivery and connections to incorporating the Truth and Reconciliation Commission of Canada (TRC) and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) into practice.

Learning Objectives

By the end of this chapter you will have had the opportunity to:

- Understand the history of social work on Turtle Island (North America) and its current impact and implications within Indigenous communities;
- Evaluate our systems of knowledge, values, and experiences that form our own belief systems, including the ways that our settler worldviews impact our work in community;
- Understand the importance of relationships and relationality with and within community; and
- Understand anti-oppressive practice in order to actively implement culturally safe, decolonized, and trauma informed practice within rural and remote Indigenous communities.

History of Settler Colonialism in Social Work

To comprehend and contextualize social work praxis, the history of colonial, oppressive and assimilative policies that were implemented and carried out by social workers must be evaluated. Historically, settler-colonial ideology disregarded Indigenous ways of being and knowing, and legally prohibited Indigenous structures and living, such as hunting and gathering, family and community, governance, knowledge systems, spirituality and culture. Settler colonialism is different from other forms of colonialism, because it includes taking control of the land and all things in its domain (Tuck & Yang, 2012). Social workers were an essential element of the ongoing “assimilative policy projects” implemented by the government, which attempted to destroy

Indigenous identities, families, communities, relationships, languages, and knowledge systems (Hart et al., 2010, p. 20), and carried out actions to maintain social control (Pugh & Cheers, 2010).

In the context of micro, mezzo and macro practice, many Indigenous worldviews identify that systems of individual, community, and nation are inseparable, and are interrelated within the understanding of wellbeing and kinship. Policies, legislation, and legally-binding documents were established, such as the treaties, the Constitution Act (1867), and the Indian Act (1876), to dismantle and extinguish Indigenous identities (micro), families and communities (mezzo), and Indigenous structures, systems, and governance (macro) (Greenwood et al., 2017).

The attempt to extinguish Indigenous identity (micro) included prohibiting spiritual and cultural practices, speaking Indigenous languages (such as within the Indian Residential School (IRS) system), and changing Indigenous names to more white-colonizer sounding names through treaties and residential schools, as residential "schools were attempting to make "little white children out of little red children"." (Aboriginal Healing Foundation, 2006, p. 2). Settler-colonial ideologies of a superior race (white), or the notion to "kill the Indian in him, and save the man" (Pratt, 1892), have profound effects on Indigenous identity, which can lead to internalized colonialism (Bleau & Dhanoa, 2021). Internalized colonialism and denying Indigeneity, or ties to Indigenous background, can be maintained intergenerationally through family as a protection from alienation and ostracism from mainstream society.

Family and community systems (mezzo) were broken and legally separated through forced assimilation, including mandatory attendance at Indian Residential Schools (IRS), and the forced removal of children from their families, and illegal adoptions, during the Sixties Scoop. It was believed that removing Indigenous children from their families would rid Indigenous communities of their traditional ways and languages—referred to as "savage"—in order to assimilate Indigenous children into a "higher race" of the "English-speaking and civilized" (*Official Report of the Nineteenth Annual Conference of Charities and Correction*, 1892). Approximately 150,000 children attended Indian Residential Schools (IRS) from 1870 through the 1990s (Walker, 2015). In 1892, Richard H. Pratt, founder and superintendent of the Carlisle Indian Industrial School, stated:

> *A great general has said that the only good Indian is a dead one, and that high sanction of his destruction has been an enormous factor in promoting Indian massacres. In a sense, I agree with the sentiment, but only in this: that all the Indian there is in the race should be dead. Kill the Indian in him, and save the man. (Official Report of the Nineteenth Annual Conference of Charities and Correction, 1892)*

Pratt's ideology fueled the disregard for Indigenous life. The death rate of Indigenous children in Residential Schools itself is considered an act of genocide, with some schools having a death rate of 40% (Truth Commission into Genocide in Canada, 2001). Indian Hospitals targeted individuals and performed illegal / abusive medical procedures, including sterilization of women and girls, often without pain medication (Truth Commission into Genocide in Canada, 2001).

Under the Indian Act (1876) Indigenous systems (macro) were dismissed or legally prohibited, such as systems of governance, cultures, and ceremonies, and the forced and mandatory relocation to reserves. Some policies could be considered imprisonment, such as the Pass System, which prohibited Indigenous individuals from leaving the reservation without a legal "pass" from an Indian agent (Johnson, 2020). Individuals could be incarcerated for leaving reservations, even for survival purposes, such as hunting, fishing and gathering, or visiting with relatives (Johnson, 2020). Reservations could be viewed as mass prisons, which were controlled through Indian Agent surveillance.

The settler colonialism that occurred within Turtle Island (North America) was genocide, resulting in the extinction of over 90% of some populations (Greenwood et al., 2017). Indigenous people were viewed as unworthy of occupying space, as Pratt states "they occupy so much more space than they are entitled to either by numbers or worth" (*Official Report of the Nineteenth Annual Conference of Charities and Correction*, 1892). Indigenous people were viewed as weak by colonizers, and it was assumed that Indigenous people would become extinct or fully assimilated (Greenwood et al., 2017; Tuck & Yang, 2012).

Greenwood et al. (2017) state that colonizers viewed Indigenous people as inherently weak and prone to sickness and therefore policies were implemented to reflect a paternalistic "protection." Robidoux and Mason (2017) assert that settler-colonial control was justified by colonizers, because the ideology of success was associated with mass production, profit, and thus power. Indigenous ways of being and living, such as communal hunting, fishing, gathering, and equitable sharing lacked the basis of mass

agricultural production and did not conform to the principles of capitalism. Pratt stated that he believed Indigenous people lacked the ability to exploit the land for their own use, which he viewed as foolish (*Official Report of the Nineteenth Annual Conference of Charities and Correction*, 1892). For this reason, Indigenous ways of living were not highly valued, and thus directed by settler-colonial policies; Indigenous Nations were forced to farm, rather than to hunt and gather.

Indigenous people were robbed of their Indigeneity, land, culture, traditions, language and kinships in the name of colonialism and capitalism. These injustices stripped Indigenous peoples of the ability to exercise their autonomy to suit their own needs and interests (UNDRIP, 2008).

Settler Colonialism roots in Social Work

Social workers have been historically complicit in the unjust treatment of Indigenous people, as they played an active role in the kidnapping of Indigenous children for both Indian Residential Schools (IRS) and the Sixties Scoop. Social workers accompanied Royal Canadian Mounted Police (RCMP) officers to seize Indigenous children from their families. This act of illegally displacing Indigenous children continued into the era of the Sixties Scoop, where Indigenous children were fostered by, or adopted into, non-Indigenous families. As viewed through settler-colonial ideologies, which formed the profession of social work, Indigenous people and families were perceived as a "problem," who could be "saved" from their "dysfunctional" selves, families, and communities (Australian Human Rights Commission, 2001). Indigenous people were also viewed as "savages" who were captive to their nation's / tribe's "savage language, superstition, and life" (*Official Report of the Nineteenth Annual Conference of Charities and Correction*, 1892).

Assimilation policies and colonial violence have led to a widespread Indigenous distrust of the government and those who occupy "white" government agencies (Pugh & Cheers, 2010). The historical policies and proceedings continue to carry deeply ingrained colonial and systematic forms of oppression which have continued the displacement of children into child welfare systems—constructing a pipeline to prison—and exacerbated psychological trauma and physical illness (Hart et. al., 2010; Johnson, 2020; TRC, 2015).

Fortier and Wong (2018) state that social work and the implementation of social services has "been created out of the trauma of dispossession," which discounts Indigenous systems and knowledges and instead "work[s] with the more muted goals of alleviating the worst suffering while consciously or unconsciously supporting the ongoing process of dispossession" (p. 444). Thomas and Green (2020) encourage us to ask ourselves, as social workers, how historical oppression, assimilation and genocide contributes to community members' perceptions of, and comfort with, social workers. They note that if a social worker were to ask an Indigenous community member or a family, "What is a social worker?" and "How would your ancestor answer this question?" (Thomas & Green, 2020, p. 92), the response might be shaped by personal worldviews and historical betrayal. We must recognize how and why social work was implemented in Indigenous communities, embodied as saviourism, in order to dismantle and deconstruct our understandings of social work with Indigenous people and within Indigenous communities. Once this is recognized, we can then re-create our roles as helpers and healers in community.

Rural and Remote Indigenous Community Practice

Rural and remote communities lie outside cities, and often have less access to resources and services, such as those associated with health and education. Rural communities are defined as having a population of fewer than 1,000 people living outside urban areas (Statistics Canada, 2018). Rural has been described as a physical place, climate, and economy; its resulting social context is regarded as remote or isolated, with sparse populations and limited services (Pugh & Cheers, 2010; Schmidt, 2010). However, Martinez-Brawley (2000) has recommended referring to these areas as "small communities" rather than specifically defining and labeling these areas as rural.

Collier (1984; 1993; 2006) states that "rural" is colonially defined, and has been used to name the places that Indigenous people occupy, which are often less valued spaces. Specifically for Indigenous people, the concept has been developed and based on settler-colonial standards and decisions of forceful creation of space, borders and determining resources (Pugh & Cheers, 2010; Schmidt, 2010). Rural areas that Indigenous people occupy, such as reserves which account for approximately 0.2 – 0.4 percent of land in Canada, are often utilized for resource extraction, such as through placing pipelines, that have adverse effects on health and wellbeing (Joseph, 2018; Kestler-D'Amours & O'Toole, 2019).

The lack of community resources for coping with these adverse health effects on rural communities will be discussed later in this chapter. Pugh and Cheers (2010), and Schmidt (2010) define rural as an understanding of the lack of resources available in that

community. Lack of resources that are often available within cities or urban areas, may include health care (hospitals, nurses and doctors), education, mental health supports and services, substance use and harm reduction services, courts or probation offices, offices for social development (license, identification, health care documentation), grocery stores, and more.

Comprehending rural social work praxis through an anti-oppressive practice lens also includes understanding how rurality has been created and defined. Schmidt (2010) refers to Collier (1984; 1993; 2006) when speaking about the history of social work, stating that social work functioned to moderate capitalism and preserve the status quo by maintaining a certain dynamic of power and control within rural communities. Social workers must understand the current realities and inequities found in rural areas and small communities by knowing that these communities are a product of settler colonialism through exploitation and underdevelopment, leading to the elitism of settlers (Zapf, 1985). Elitism was created by utilizing government entities, such as Indian agents, and later, social workers, to direct Indigenous people and restrict them. For example, government administrations intentionally restricted Indigenous people's access to food, such as attempting to eliminate the buffalo, followed by implementing government "policies that ensured failure rather than encouraged success" (Bateman, 1996, p. 12). Indigenous people were forced to live on reservations, which were intentionally placed on lands that were deemed unsuitable for sustainable farming (Bateman, 1996). Inadequate farming equipment was distributed to Indigenous people, compared to that of the neighbouring settlers, who were actually allotted land well-suited for farming (Bateman, 1996).

Social workers historically preserved elitism, by:

> *Promoting the potential development of one set of people at the expense of another set of people (elitism); that suggest that one set of people have greater human potential than another set of people (gender, racial inequality) or that deny that one or more set of people have human potential (oppression, slavery). (Delaney, 2009, p. 18).*

The continuation of "relief" food was preserved through the work of social workers, continuing restrictive practices and promoting dependence on the government rather than encouraging sustainability and community development (Fortier & Wong, 2018).

Social Work in Rural and Remote Communities

Instead of replicating social work practice and service patterns that are common within other geographical areas, such as cities and urban areas, social workers must consider the history of ruralism and the unique needs of these communities (Pugh & Cheers, 2010). This shift can be achieved through both a culturally-safe framework and a generalist social work practice approach. Generalist social work practice involves remaining "skilled in working with individuals, families, small groups, organizations and communities" (Locke & Winship, 2005, p. 6) while also having a role as a resource navigator. For example, to combat the lack of resources, some Indigenous communities in British Columbia have resourced groups, such as Wellbriety, which deliver group counselling sessions while also integrating capacity building and resource navigation, such as equipping community members with harm reduction training and supplies. Other resource navigation approaches involve advocating for community members to have equitable access to resources, through video or Telehealth calls to health care workers such as nurses, doctors, psychiatrists, or courts and probation services.

A generalist practice approach is helpful within rural areas or small communities because social workers have many roles, which requires the ability to be multifaceted or versatile in order to meet the needs of the community member. As a social work colleague stated to me: "We work with whatever needs people have when they walk through the door" rather than engaging in a singular role (J. Kent, personal communication, February 2019). In restricting social work to a singular, specialized role or approach within rural communities, community members' needs are not met. For example, some rural communities lack specific A&D workers (alcohol and drug workers). A social worker may not have the precise skillset or knowledge to complete addictions treatment applications with a client but is still considered "qualified" to fill that role. It is important to be adaptable and "general" or broad in being flexible in learning various skillsets or applications/assessments, so that community members are able to access appropriate services.

Anti-Oppressive Education & Practice

Rural Indigenous communities, which include reservations, were created to control, segregate, displace and oppress Indigenous people. Anti-oppressive practice acknowledges the historical injustices that have occurred, and actively works to prevent further harms from occurring. This section reviews historical forms of oppression, while evaluating how education is often dominated by

settler-colonial views. It also explores fundamental elements of anti-oppressive practice, including the role of building relationships, cultural safety, decolonial praxis and trauma-informed practice. It is imperative to understand the importance of these unique practices, as they all uphold anti-oppressive values. Anti-oppressive practice is achieved by listening to, and implementing, the ways in which individuals and communities envision their healing, without overriding their decisions with one's own personal biases or worldviews. Part of this process is to implement Two-eyed Seeing (Western and Indigenous healing methods and ideologies), rather than strictly encouraging colonial therapies and pathologizing, or "diagnosing" Indigenous experiences. Two-eyed Seeing incorporates both Indigenous and settler-colonial knowledge. Greenwood et al. (2017) describe Two-eyed Seeing as "walking into two worlds" and recognizing the strengths of both Indigenous and settler knowledge systems (p. 183). Social workers can engage in anti-oppressive and decolonized practice by invoking community members' ideas for individual healing, as well as program and workshop development, while also resourcing decolonized therapeutic interventions, rather than resorting to mainstream evidence-based practices, which often fail to understand Indigenous ideology and cultural safety.

Anti-Oppressive Practice and Settler-Colonial Education

It is important to examine how our pre-conceived notions or indoctrinations, that are a result of the systems in which we live and work, are maintained by systems of settler colonialism. As a social worker within a colonially dominant culture, I recognize many social workers have been indoctrinated in colonially-developed education systems that tailor intellect in order to fit into mainstream practice (Johnson, 2020; Linklater, 2016). Johnson (2020) states that students (both Indigenous and non-Indigenous) are taught to exclude diverse knowledge systems, such as Indigenous knowledges, and instead are persuaded "to think like a settler" (p. 39). Maracle (1996) states that "the appropriation of knowledge, its distortion and, in some cases, its destruction, was vital to the colonial process" (p. 89). The settler-colonial assimilation process was intended to conform education to the cultural, social and political beliefs of the settler (Thomas & Green, 2020). It was a settler-colonial assumption that Indigenous epistemologies were inferior, which created internalized racism, and supported the settler agenda of domination and colonization (Thomas & Green, 2020).

Thus, we must examine how teachings and training influence our relationships within social work practice. It is important to challenge the settler-colonial paradigms that dominate education, including social work education, which reinforce "altered forms of consciousness" and often separate the head (cognition) and heart (feelings) (Thomas & Green, 2020, p. 43). Settler-colonial education training is often objective, with the direction to assess, recommend, and implement (Thomas & Green, 2020). Many Indigenous traditional paradigms refer to relations and connections with family, community and the land (Gaudet, 2017; Thomas & Green, 2020), as a base for teaching through learning, watching, listening and participating (Stiffarm, 1998). We must examine how we are trained to write case notes and documentation, and we should question whether those case notes are strengths-based and non-pathologizing. Are we acting and writing in a way that best supports the community member? Are we respecting Indigenous traditional teachings within social work practice (Thomas & Green, 2020)? In asking these questions, we can actively evaluate if the social work praxis follows anti-oppressive practice principles.

Anti-Oppressive Practice

The incorporation and implementation of a decolonized, trauma-informed, culturally-safe framework and relationship building is fundamental to anti-oppressive social work practice within Indigenous communities. These frameworks, and how they associate and complement each other, will be discussed more in depth in future sections. In adhering to anti-oppressive practice, certain terms and labels are altered within the body of this chapter, such as replacing the term "client" with "community members," to diminish the power imbalance and hierarchy that the word "client" may carry. Thomas and Green (2020) state that anti-oppressive practice should include analyzing power differences, examining methods of helping and healing, and exploring who we are and how this practice affects our relationship with people who have been historically and contemporarily marginalized.

A settler-colonial mentality has held the belief that Indigenous peoples and communities need to adapt to settler life and heal and nurture themselves in an evidence-based, specific way. Part of anti-oppressive practice is developing unique plans and programs based on collaboration with the community member and larger community, and utilizing flexibility and creativity rather than prescribing an intervention based solely on clinical perspectives. Clinical perspectives are formed around settler-colonial ideologies and often apply a restrictive biomedical model. As such, it is important to use a client-centered and generalist approach, which recognizes social inequalities while being flexible and versatile in meeting community members' needs. One way of practicing this may be through developing a holistic healing plan.

A holistic healing plan is flexible, fluid and non-pathologizing. It focuses on the goals of the community member, while also exploring strengths in themselves and their community. A holistic healing plan may include incorporating the medicine wheel to understand how an individual identifies their strengths and areas for improvement mentally, emotionally, physically, and spiritually. However, it should not be assumed that every community uses the medicine wheel. In adhering to an anti-oppressive approach, a holistic healing plan needs to be led by, with, and for the community member, rather than pathologized and clinically created solely by the social worker. A healing plan may also incorporate Indigenous forms of healing and ceremony, although this should not be assumed or enforced based solely on a person's Indigenous heritage.

Role of Building Relationships

Building relationships within community and with community members, while maintaining relational accountability, is a fundamental element of anti-oppressive practice, and a pillar of culturally-safe, trauma-informed, and decolonized practice. Wilson (2008) describes relational accountability as demonstrating and practicing respect, reciprocity and relationality (The three Rs). Building relationships is essential to establishing trust and respecting boundaries, and is a crucial element of the therapeutic relationship. Creating relationships with community members is a process, and not an inherent right; this must be earned. As previously mentioned, it is important to understand that the process of relationship building with community members can be affected by the trauma inflicted by settler-colonial structures such as health care and social services. Recognizing the historical reasons social workers are viewed as untrustworthy or unsafe is imperative in understanding how current safety is experienced (Greenwood et al., 2017).

When working as an Indigenous or non-Indigenous/settler person within a community that is not your own, it is essential to adapt social work practices by identifying oneself as a guest within the community, and not as an "essential" component. This practice is a part of relationship building, and may include disclosing personal information such as who you are, where you are from, what your cultural background is, how your family relates to Turtle Island, where you went to university/college, and why you are in the community. Sharing and discussing these aspects of self is a way to build relationship and dissolve some characteristics of colonial power dynamics, which can often create a hierarchy of power and control, rather than establishing a trusting, relational practice.

As previously discussed, part of relationship building includes placing oneself as a guest in the community, rather than exercising a role of power and hierarchy, while also sharing personal information in order to create the dynamic of relational social work practice. Community engagement and building relationships might be achieved by honouring/accepting invitations from community members for events, which may coincide with cultural protocol in some communities (Greenwood et al., 2017). Honouring the advice and knowledge of community Elders and knowledge keepers is also imperative in efforts to respectfully engage with community, and coincides with the three Rs by respecting traditional knowledge systems.

Schmidt (2010) notes that it is not uncommon for a rural or remote community to evaluate social workers' behavior, intentions, personal interests, and groups the social worker is connected with, alongside making inquiries to the social worker that may be considered as "intrusive questions" (p. 12). When we continue to ask community members about their own lives, without disclosing some information about ourselves, it creates a division which is often hierarchical. From a decolonial, culturally-safe perspective, actively participating in relationship building requires relinquishing settler-colonial habits, such as hiding our personal identities as a form of safety, while continuing to analyze community members from a position of power.

Genuine, active listening and engagement are imperative to understanding how individuals envision their healing, through co-creating and recognizing Two-eyed Seeing, rather than imposing colonial therapies and pathologies. A co-creator is a helper who collaborates with community members on their wellness, rather than exclusively deciding and delegating how they should conduct their wellness. Schmidt (2010) recognizes that relationships within rural / small communities are unique because connection and integration with community members is more frequent. Establishing trusting relationships is an important part of forming thoughtful discussions. Genuine and thoughtful discussions are an important part of acting as a co-creator within community engagement, and implementing community members' ideas for programming, workshops and decolonized therapeutic interventions; social workers should not resort to mainstream evidence-based practices, which often fail to understand Indigenous ideology and cultural safety.

Evidence-based practice in social work has been informed and developed by those with power, as a result of both global and local informational systems of science, positivist and rationalist practice (Beddoe, 2007; 2013). Evidence-based practice thus excludes Indigenous knowledges, and traditional relational approaches to treatment (Beddoe, 2007; 2013). For example, being on the land

(in nature), speaking with Elders and knowledge keepers, harvesting and using traditional medicine, and being involved in traditional ceremony enhance physical/biological, mental, emotional and spiritual wellness. These approaches to wellness do not fit the scope of evidence-based practice, and instead settler-colonial therapies and medicines, often developed for and by non-Indigenous people, are recommended. Part of relationship building is to explore what the community member views as healing, which may include the Indigenous methods listed above.

Another aspect of relationship building is understanding role conflict. Schmidt (2010) speaks about the importance of understanding role conflict when building relationships within rural Indigenous communities, as "outsiders coming in" (social workers, non-community members) or "insider[s] coming back" (social workers, who are also community members), and the complexities that they may face (p. 13). Role conflict recognizes the possible difficulties of navigating the lack of anonymity and immersion into the rhythm of community (Schmidt, 2010).

Relationship building is hence a combination of understanding the power dynamics of being a guest in community, building genuine relationships, actively engaging with community, and respectfully understanding community protocol and expectations. Relationship building is imperative in safely and respectfully engaging with community members and with the larger community as a whole.

Cultural Safety

Cultural safety is necessary for practicing anti-oppressive social work within Indigenous communities because of the legacy of colonialism which has created inherent power imbalances. Cultural safety is different than cultural competence. Cultural competence is pan-Indigenous, presuming that all Indigenous nations / communities share the same systems of belief (Yeung, 2016). Cultural safety recognizes the power imbalance between the social worker and the community member, while evaluating the cultural expectations that define treatment and deem which traditions are honoured (Greenwood et al., 2017; Yeung, 2016). Cultural safety is thus a practice of "shifting focus to the experiences of the person receiving care" rather than relying on preconceived ideas or beliefs about a community or nation (Greenwood et al., 2017, p. 182).

Cultural safety prioritizes Indigenous sovereignty and challenges societal hierarchies while necessitating safe practice (Yeung, 2016). Blaikie (2009) states that cultural safety is necessary because of social work codes of ethics and standards of practice which neglect to acknowledge "contextual, cultural and political realities for Indigenous [people]" (p. 3). The characteristics of cultural safety include knowing the history of colonization and its implications within social work practice and society as a whole; adapting social work practice to be community-driven and delegated; following and respecting community protocol while also working with Elders; and working *with* rather than *on* Indigenous people, because Indigenous people are experts of their own lives (Kurtz, 2013).

Cultural safety includes adhering to Indigenous knowledge systems and methods of delivering services and understanding Two-eyed Seeing (Greenwood et al., 2017). Two-eyed Seeing dismantles the ideology that healing must be delivered through settler-colonial, evidence-based practices, which ignore and exclude Indigenous knowledge systems as valid, and instead allows the incorporation of both. Crystal Morris, Indigenous traditional medicine practitioner from the Splatsin (Secwepemc) and Tsartlip (WSanec) nations, describes the concept of two-eyed seeing as recognizing the importance of healing methods and herbs that are indigenous to Turtle Island, as well as those that have been introduced through colonialism, in order to support community members and their individualized healing effectively (Morris, 2021).

Two-eyed Seeing creates an ethical space of practice and cultural humility, where Indigenous and non-Indigenous community members and practitioners can establish a safe space for collaboration, creativity and inclusivity—to listen, understand and dream together—in order to move forward (Greenwood et al., 2017). Cultural humility acknowledges that, as practitioners, we commit to a lifelong journey of continued self-evaluation, reflection, and learning, so that we can understand ourselves and our practice (Greenwood et al., 2017). Cultural safety is a way of being both within community practice, and simultaneously in daily individual practices (Kurtz, 2013). Understanding these concepts of cultural safety upholds and respects that healing must be rooted in Indigenous knowledge and values in order to actively support the restoration and reclaiming of these knowledges (Greenwood et al., 2017).

Decolonial Praxis and Connection to Social Work Practice

Colonization is the forced domination and hierarchy that the colonizer creates over the colonized (Kelm, 1998). Social work was developed by settlers and is maintained through settler-colonial structures. Patrick Wolfe (2007) states that "alism is a structure and not an event" (p. 5), highlighting the continuation of colonialism within structures intended for healing, including social work. For

this reason, within anti-oppressive practice, social workers must recognize the importance of decolonial praxis. The ambition of absolute decolonization includes prioritizing Indigenous sovereignty, land rights and self-determination (Gahman & Legault, 2017), including the structures intended for health and healing.

Decolonial praxis actively prioritizes Indigenous knowledges, practices, and traditions, and thus works to coincide with cultural safety. The process of decolonization involves challenging settler-colonial policies and systems, so that Indigenous people can "be informed agents of their own lives and healing journey" (Lu & Yuen, 2012, pg. 192). This means to encourage Indigenous sovereignty (decision making) and advocate for Indigenous rights. An example of this may be through challenging systems such as the criminal justice system and adhering to a probation order; for example: advocating for traditional systems of healing (attending a restorative justice healing circle, as a part of a probation order), rather than adhering to settler-colonial law (attending an anger management course as a part of a probation order). Sinclair (2004) affirms that decolonial praxis addresses the historical and current settler-colonial impacts that are maintained through "colonial culture and social suppression, intrusive and controlling legislation, industrial and residential school systems, the child welfare system, and institutional / systemic / individual racism and discrimination" (p. 76).

However, some practitioners, such as Fortier and Wong (2018), state that decolonizing social work is impossible, because the field was developed and is maintained by colonialism. Therefore, Fortier and Wong (2018), call for an unsettling of social work, through:

> *Deprofessionalization (the restructuring of the 'helping' practices of social work back under the control of communities themselves); deinstitutionalization (fighting against the non-profit industrial complex and re-focusing on mutual aid, treaty responsibilities, and settler complicity); and resisting settler extractivism (working towards the repatriation of land, children, and culture and the upholding of Indigenous sovereignty and resurgence). (p. 447)*

Part of decolonial social work practice is examining ways in which social work may continue to perpetuate colonial harm. Tuck and Yang (2012) warn against settler harm reduction, which is the act of reducing the harms caused by settler-colonialism, but not seeking to give up privilege, power, and control exercised over Indigenous people and communities (Tuck & Yang, 2012). An example of settler harm reduction would be to focus on a person's substance use (micro) as the root of their problem, rather than to evaluate the societal and historical impacts (macro) of colonialism, such as lack of housing, land, and resources. As Michelle Alexander (2020), a Black civil rights advocate, states: "we must not be seduced into believing that improving the system is the same as dismantling or transforming it" (p. xxxvii). Practicing this form of settler harm reduction is a method of settler-colonial innocence and continued compliance with the macro structures of colonialism (Tuck & Yang, 2012). Decolonial praxis is thus unsettling social work, rather than attempting to supplement or Indigenize social work (Tuck & Yang, 2012).

Trauma-Informed Practice

The term "trauma" has been created by settlers and has been used to diagnose and pathologize Indigenous experiences of pain and suffering (Linklater, 2016). Furthermore, colonialism is at the root of Indigenous trauma, and this element must be identified in order to take away the blame and shame of trauma from individuals and families (Linklater, 2016). Burstow (2003) describes trauma as "not a disorder but a reaction to a kind of wound" (p. 22). The impact of trauma should be considered interpersonally and intergenerationally, as well as understand the transmission of traumatic experiences and learned behaviours from previous generations. Trauma can affect a person's (micro) and community's (mezzo) holistic well-being, emotionally, physically, socially and spiritually, and can be maintained through settler-colonial structures (macro).

For social workers, trauma-informed practice is client-centered and includes being actively aware and conscious about how a community member has been harmed (mentally, emotionally, physically, spiritually) and perceives themselves and their safety in the world. Trauma symptoms, such as "arousal, attention, perception and emotion" can sustain "in altered and exaggerated states long after the specific danger is over" (O'Neill, 2005, p. 75). It is therefore important to acknowledge and recognize that a person's experience of the present state can be impacted by the trauma they suffered from previously. Trauma-informed practice understands the individual impact of trauma, which is often a result of colonially-created systems (Linklater, 2016), and "strive[s] to provide

programs and services which avoid retraumatizing people while supporting their movement towards resilience, recovery and wellness" (Randall & Haskell, 2013, p. 517).

Fortier and Wong (2018) refer to Tuck and Yang (2015) when speaking about how social workers can unintentionally re-traumatize Indigenous people and that we, as social workers, "must recognize settler complicity in colonial violence" (p. 447), which can devalue the experiences of community members. Trauma-informed practice includes culturally-safe practice, recognizing the individual impacts that physical spaces (waiting rooms, offices) can have on a person, and can be perceived as violent or threatening. For example, hospitals and office-settings can resemble that of residential schools, and can cause an inherent visceral trauma reaction (Chansonneuve, 2005). Trauma can also endure through other physical settings such as classrooms, hospitals, and social service offices, which can be seen as unsafe (Brunzell et al., 2016; Perry, 2006). Therefore, being trauma-informed includes being actively engaged in dialogue, identifying the ways in which a person feels safe and in danger, and adapting social work praxis to suit the needs of the community member (client-centered).

Linklater (2016) explains that Indigenous people have experienced increased alienation and trauma when seeking help. It is important to create safe spaces and adjust environments to harmonize with a community member's needs. An example of adapting spaces to feel safer can include adjusting office space, or practicing social work on the land (land-based). A social worker can engage in a conversation about what setting would make the community member feel more comfortable or safe, such as different lighting, or moving to a different location such as sitting outside. For example, a community member once informed me that the lighting in my office was too dark (it was winter, in the late afternoon and the lights were off in the centre, leaving the room shaded). Although explanations are never needed, the community member explained that they had experienced a traumatic experience in a shaded room. It is important to acknowledge these experiences and adapt the environment to the individual's need. As previously mentioned, an individual's or a community's unique experiences can cause distinct reactions to trauma. Indigenous people and communities have survived settler-colonial attempts to extinguish and assimilate them (Greenwood et al., 2017). Trauma-informed practice recognizes the resilience of community members and communities, as well as unique forms of healing.

Policy and Service Delivery Issues

Settler-colonial policy and service delivery has historically failed to meet the needs of Indigenous individuals and communities. Linklater (2016) explains that these service delivery methods were not created from an Indigenous worldview. The creation of these systems, both within the confines of physical and political boundaries of Indigenous communities, limits relevant services (Pugh & Cheers, 2010; Schmidt, 2010).

Policy and Control

When treaties were first established, Indigenous people believed that their inherent right to traditional Indigenous systems and cultures would be continued and maintained (Robidoux & Mason, 2017). As previously mentioned, current social work practice in Indigenous communities is governed by settler-colonial policy. Although work to "Indigenize" programs and policies are underway —including healing lodges, sentencing circles, restorative justice, treatment centres and health centres—these programs are still maintained and controlled by colonial systems that delegate structure and provide funding, and thus cannot be fully independent (Giannetta, 2021). Giannetta (2021) articulates that the tactic of Indigenizing current colonial systems is a means to maintain power and control, without implementing any meaningful change. An example of this failure to dismantle settler-colonial policy can be seen through examining current healing lodges within the Justice system:

> *These lodges operate within penitentiaries (a colonial institution) after an Indigenous offender has been sentenced (through a colonial justice system) for committing a crime (defined by the colonial political system) caused by underlining social issues (stemming from colonialism). (Giannetta, 2021, p. 4)*

Indigenous communities continue to strive to overcome these barriers through implementing grass roots programs and initiatives. For example, in British Columbia, the First Nations Health Authority (FNHA) is an Indigenous-created and led health authority with the "commitment to engage and privilege Indigenous health and wellness" (Greenwood et al., 2017, p. 185). However, within FNHA programs, barriers of accessibility continue to be prevalent. For example, long wait times for admission to substance use treatment centers, which can be between 1 – 3 months, can be detrimental to healing. Furthermore, similar to non-FNHA treatment centers, many FNHA treatment centers do not support access to harm reduction services and deny the individual's acceptance to

programming if they access Opioid Agonist Therapies (OAT), such as suboxone, methadone or kadian. OAT is a longer-acting opioid that decreases withdrawal and minimizes cravings for individuals who use substances such as heroin, fentanyl and oxycodone. OAT is prescribed by medical professionals. These barriers can lead to sustained or increased use of substances, and overdose.

Delivery of Service

There is undoubtedly a lack of access to social, health and extended services in rural, remote and small Indigenous communities, because of the historical displacement of and disregard for Indigenous people and communities (Pugh & Cheers, 2010; Schmidt, 2010; Zapf, 2010). Some communities have adapted to the lack of services, for example, the First Nations Health Authority (FNHA), discussed in the previous section, has implemented access to virtual doctors, psychiatrists, addictions specialists and counsellors. However, to access these services, individuals need the internet, which is often unavailable in rural and remote areas, including on reservations and in Indigenous communities.

Further injustices leading to barriers are intensified due to resource extraction, and the "rape" of the land (Hunt & Craft, 2021). One example of this is the Dakota Access Pipeline (DAPL), which was originally planned for an area that could potentially affect the water system which serviced non-Indigenous communities (McKibben, 2016). The pipeline was moved to Indigenous land, without the consent of the Standing Rock Indigenous Nation (McKibben, 2016). When Indigenous people and communities voiced their concerns, they were ignored, which led to worldwide attention, and subsequent social justice movements. However, pipelines and resource extraction not only affect the physical health of Indigenous Nations, but they also create worker camps, which directly increase the potential for physical and sexual violence against Indigenous women and girls in surrounding nations, contributing to the epidemic of Missing and Murdered Indigenous Women and Girls (MMIW) (Hunt & Craft, 2021; Macy, 2020).

Barriers to service delivery are exacerbated by a lack of public transportation options, including the cancellation of bus service provided by the Greyhound bus company (Rodriguez, 2021). Access to fewer, or no, options for transportation affects individuals' ability to access health services and appointments, education, employment and opportunities to meet and gather with family (Rodriguez, 2021). Transportation restrictions have led individuals to choose hitchhiking in order to access these services, which is a safety risk, especially for Indigenous people. The Trail of Tears is one horrific example of Indigenous peoples' disproportionate risk, referring to a stretch of road where individuals have gone missing or been murdered while hitchhiking; again, increasing the number of Missing and Murdered Indigenous Women and Girls (MMIW) (Levin, 2016).

In order to cope with these barriers, some social work practitioners recommend community-based service delivery, which utilizes Indigenous community strengths, resources and natural helping systems. Zapf (2010) refers to Nelson (1986) when recommending a model of integration of services in various communities in both Canada and Australia. Some of the communities are interagency and include recreation, education, policing and other services that are within, or close to, rural communities (Zapf, 2010). Building on strengths, skills and abilities within the community allows members to access services more quickly.

Community-based service delivery can be enhanced by building capacity within these areas. The purpose of community capacity building is to educate, consult with and train local community helpers so that they can deliver services within that community (Zapf, 2010). Building local expertise and community confidence through natural and informal helping systems is less costly and sustains services in community (Zapf, 2010). Social workers are advised to support natural and informal support systems, and not to replace or supplant (Zapf, 2010). An example of capacity building in addictions services is identifying and supporting a community champion, who may, for instance, identify with having used substances, or is using, and acts as a provider of harm reduction supplies or participates in leading community action teams.

Other barriers to service delivery in community work can include rigid rules and regulations, from "a controlling power of the state" and "conflicting expectations of state, profession, employer, and community" (Zapf, 2010, p. 74). This refers to the power and influence that provincial and federal policy and regulations have on Indigenous communities, and the disregard of Indigenous autonomy. Zapf (2010) encourages social workers to navigate these barriers by dynamically interweaving creative flexibility and collaborating in decision making with the community. Zapf (2010) further explains that social work practice becomes "more intuitive, as the worker comes to rely more on community relationships and less on the authority of knowledge" (p. 75).

Canadian Association of Social Workers (CASW) Code of Ethics

The values present within the CASW (2005) Code of Ethics that are distinct when working with rural / small Indigenous Communities include advocating for equitable services and challenging injustices [Value 2], which, as previously mentioned, are

barriers when working within these communities. The CASW (2005) Code of Ethics states that social workers must understand the power imbalance that occurs in a social work-community member relationship, while prioritizing the needs of the individual [Value 3]. Value 3 (CASW, 2005) also states that a social worker should use their professional knowledge and skills when working with a community member. However, social workers must acknowledge the history of settler colonialism and engage in collaborating and implementing Indigenous knowledge systems and healing, as these pertain to the community/community member.

Registered social workers are accountable to the Canadian Association of Social Workers (CASW, 2005), and the provincial/territorial associations and colleges, and are required to adhere to a standard of practice, ethics and values. An important focus in the CASW (2005) Code of Ethics, and stressed by Arges et. al. (2010), is that social workers have an obligation to uphold:

> *The welfare and self-realization of all people; the development and disciplined use of scientific and professional knowledge; the development of resources and skills to meet individual, group, national and international changing needs and aspirations; and the achievement of social justice for all. The profession has a particular interest in the needs and empowerment of people who are vulnerable, oppressed, and/or living in poverty. (CASW, 2005, p. 3)*

This statement is not particularly anti-oppressive in its wording, since it suggests that social workers can label and define who is considered vulnerable or oppressed, alongside highlighting the use of scientific and professional knowledge, rather than community and traditional knowledge. However, it nonetheless stresses the importance of upholding individual and community needs, and of social justice. This would suggest that the role of social workers is to work *with*, rather than *on*, community members.

The TRC and UNDRIP

The CASW (2005) Code of Ethics also mentions the importance of honoring the *Canadian Charter of Rights and Freedoms* (1982) and the United Nations *Universal Declaration of Human Rights* (1948). Other relevant reports pertaining to Indigenous people, made by and for Indigenous people, include *Truth and Reconciliation Commission of Canada: Calls to Action* (TRC, 2015) and the United Nations *Declaration on the Rights of Indigenous Peoples* (UNDRIP, 2008).

The TRC (2015) has created calls to action that specifically name and call upon social workers to be educated and trained when working with Indigenous communities, so that they will provide culturally-safe and “appropriate solutions to family healing” (p. 1). Other areas recognized in the TRC (2015) are the call for recognizing and valuing community-controlled Indigenous healing practices and working with Indigenous healers and Elders. Giannetta (2021) reflects on these elements when stating that systems of healing and being must be implemented, and not expected to “operate within the confines and to the discretion of” settler-colonial systems (p. 7).

Social workers should be educated about the implementation of UNDRIP and honour / abide by the Indigenous collective rights therein (Greenwood et al., 2017). UNDRIP (2008) calls for the restoration, reclamation and sharing of Indigenous knowledge of health, while also acknowledging the settler-colonial influences in “harmful systems, organizations and relationships” that perpetuate harm (Greenwood et al., 2017, p. 182). Indigenous knowledge is “embedded in Indigenous languages, cultures, lands and territories, and laws and ceremonies” and must be implemented, in a culturally-safe way, into social work practice (Greenwood et al., 2017, p. 182).

The UNDRIP (2008) document calls upon settler-colonial policies and practices that disregard Indigenous practices as invalid to be abolished. UNDRIP (2008) states that Indigenous people have the right to exercise their rights, which include having autonomy in individual and community decision making, and maintaining and practicing holistic (mental, emotional, physical, spiritual) health practices, including traditional medicine and ceremony; it also stresses the right to live on their traditional territories and access resources, preventing further dispossession. UNDRIP (2008) identifies the boundaries that Canada and the Canadian government is required to adhere to, including working harmoniously with Indigenous people by recognizing and granting Indigenous sovereignty and rights, and by also dismantling and deconstructing any forms of assimilation or destruction of culture. UNDRIP (2008) further indicates that the State must allow for Indigenous nations to maintain and/or re-develop Indigenous institutions for decision making.

Conclusion

Audre Lorde's famous essay articulates, "the master's tools will never dismantle the master's house" (1984). The tools of settler-colonialism have created a system of social services and social work that has not developed to maintain the wellness of Indigenous communities. The core of anti-oppressive practice is to actively engage in decolonization and advocating for autonomy for Indigenous people and communities, while practicing social work with a culturally-safe and trauma-informed lens. It is through these relationships and practices that social workers can create a new narrative as active co-creators and healers within Indigenous communities, rather than continuing to practice as settler-colonial saviours.

Denica Dione Bleau, is a Red River Métis and mixed-settler scholar, social worker, trauma counsellor, advocate, artist, and PhD student. Denica is originally from Treaty 4, and has worked/volunteered within the communities of Treaty 4, Secwepemc and Syilx Territories, Pictish and Gaelic Celt (Celtic) Territories (Scotland), and Incan Territory (Peru), in the realms of counselling and social work within prison and following release. Denica's research currently focuses on Indigenous Land-based healing from the effects of criminalized and institutionalized trauma.

Activities and Assignments

- Personal Research: Understand yourself/family/community history on Turtle Island.
  - Did your family immigrate to Turtle Island, and (if so) when and from where?
  - What cultures / languages did your ancestors practice / speak? Do you practice / speak these cultures and languages?
  - Has colonialism / settler colonialism affected you or your ancestors, and how?
- Community relationships:
  - In evaluating the chapter contents, which ways might dominant social work differ from community social work in Indigenous communities?
  - CASE STUDY: Imagine you are a new social worker within an Indigenous community. A community Elder visits you at the office and begins to ask you questions about your reason for being in community. How can you respond in an anti-oppressive, culturally- safe, trauma-informed way?
  - CASE STUDY: A community member, with whom you have worked with throughout their healing journey and goal of sobriety, "graduates" from their substance-use treatment program. At the ceremony, the community member gifts you with a craft they had made. How do you navigate community protocol and the ethics of the CASW?

Additional Resources

- Linklater, R. (2016). *Decolonizing trauma work: Indigenous stories and strategies.* Langara College.
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Book Contributors

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Authors

Dr. Bonnie Jeffery

Dr. Bonnie Jeffery is a Professor in the Faculty of Social Work, University of Regina and a Researcher with the Saskatchewan Population Health and Evaluation Research Unit (SPHERU). She teaches in the areas of social work research, social work in rural and remote communities, community development, and social policy and practice with older adults. Her research program is focused on community-engaged work with rural communities to enhance social inclusion and support successful aging for older adults.

Dr. Nuelle Novik

Dr. Nuelle Novik is an Associate Professor in the Faculty of Social Work at the University of Regina and is a Researcher with the Saskatchewan Population Health and Evaluation Research Unit (SPHERU). Her research program is focused on older adults and aging, dementia, rural and remote practice, health and mental health, community engagement and community-based research. She teaches courses focused on mental health; management and organizational theory; end-of-life care and grief; counselling theories, approaches and practice; practice and policy relevant to older adults and aging; as well as social work in rural and remote communities.

Contributors

Dr. Amber Miners

Dr Amber Miners, MD, FRCPC is a general Pediatrician who has lived and worked in Iqaluit, Nunavut since 2010. She is a graduate of Queens University (MD) and Ottawa University (Pediatrics), and has gone on to complete extra training in child abuse/maltreatment, which is her passion. She currently holds academic appointments with the University of Ottawa and Memorial University. She is proud to have worked with a dynamic team at the Arctic Child and Youth Foundation to open the Umingmak Child Advocacy Centre (CAC) in 2019, where she is currently the Physician Lead. This is the first CAC in the territories. She also sits on the Trauma Aware National Advisory Committee, and the National Canadian Pediatric Society Board. She has previously been on the Royal College Regional Advisory Committee. She is the proud mother of four children.

Brent McKee

Brent McKee is a Senior Mental Health social worker with the Saskatchewan Health Authority, with the majority of his career has been in the east central part of Saskatchewan. Working in a rural setting has led to variety of social work opportunities in the Mental Health arena. Currently, Brent's focus is working with resilient families who have children under the age of 3 years with the KidsFirst Program. Maternal mental health is his current practice, focusing on the themes of empowerment, trauma informed and collaborative care.

Dr. Carrie LaVallie

Dr. Carrie LaVallie is a Registered Psychiatric Nurse and faculty in Indigenous Health at the First Nations University of Canada. They are a settler on Turtle Island with Scandinavian and German ancestors. Their research program explores spirituality's role in healing from addiction, Somatic Experiencing and mental health concerns, and decolonizing research and treatment approaches. Decolonizing practices involves harmonizing multiple ways of knowing and co-creating new knowledge.

Dr. Cathy Rocke

Dr. Cathy Rocke is the Dean of the Faculty of Social Work at the University of Regina. Prior to her academic career, Cathy worked for over 25 years in both the education and social work fields, with her practice work experience included developing postsecondary educational programs for Indigenous communities, diversity training for child welfare professionals, quality assurance for child welfare agencies, counseling women who were victims of domestic violence, and child protection. In her almost 20 years of experience in the child welfare field in Manitoba, she worked in urban, rural and Indigenous child welfare agencies at both the front line and policy levels.

Dr. Colleen McMillan is an Associate Professor in the School of Social Work, Renison University College, University of Waterloo. She is also a Scientific Co-Director of the KDE Hub which is a research hub focused on mental health promotion across Canada. She teaches in social work, medicine and pharmacy and continues to practice clinically. Research interests include qualitative health methodologies, gender and health, mental health and pedological innovation.

Curtis Hart

Curtis Hart is a registered social worker (B.C.) who was born and raised on Treaty 4 Territory, homelands of the nêhiyawak, Anihšināpēk, Dakota, Lakota, and Nakoda, and the homeland of the Métis/Michif Nation. Presently, he is an operations Manager with Mental Health and Substance Use, Island Health located in Victoria, BC, the unceded land of the lək̓ʷəŋən speaking peoples, known as the Songhees, Esquimalt and W̱SÁNEĆ peoples. He has held several positions including clinical research associate, therapist, sessional lecturer (social policy and counselling theories and skills), clinical caseworker, working in both inpatient and outreach settings. Present areas of focus include complex care housing and responses to the toxic drug supply which includes the implementation and evaluation of the housing overdose prevention and peer services (HOPPS) model.

Daniel A. Afram

Daniel Afram is a social work Clinician who is passionate about the areas of childhood trauma and concurrent disorders within systemically marginalized communities. His work is focused on equitable mental wellness policies for Inuit in addition to ongoing clinical practice with children and adolescents.

Denica Dione Bleau

Denica Bleau is Red River Métis, from Treaty 4 Territory (Saskatchewan). Denica is a PhD student in the Community Engagement, Social Change and Equity (CESCE) – Interdisciplinary Program at the University of British Columbia, Okanagan. Denica's PhD focuses on Indigenous Land-Based Healing from the Effects of Criminalized and Institutionalized Trauma. Denica's previous writings and research focus on community-based healing programs, decolonial practice, and the parallels of incarceration and genocide.

Denise Humphreys

Denise Humphreys is a white Ukrainian settler scholar living in Treaty 6 territory. She brings an interdisciplinary perspective from her Bachelor of Social Work and Master of Public Administration to her current graduate studies at the University of Manitoba and research work at Brandon University. Her work focuses on critical genocide and anti-racist education, with a particular emphasis on connecting anti-colonial knowledge to community practice.

Dillon R. Lewchuk

Dillon Lewchuk is a Registered Clinical Counsellor (B.C.), Canadian Certified Counsellor and Registered Canadian Art Therapist. He was born and raised on Treaty Four Territory, homelands of the nêhiyawak, Anihšināpēk, Dakota, Lakota, and Nakoda, and the homeland of the Métis/Michif Nation. Dillon has worked for various agencies across Canada supporting marginalized folks experiencing distress, violence and mental health disorders. He currently works at a private, inpatient facility that focuses on post-traumatic stress disorder and addiction treatment. As well, he is an instructor for the Winnipeg Holistic Expressive Arts Therapy (WHEAT) Institute teaching in the areas of gender and sexuality, child and adolescent development, addiction, PTSD and crisis support. Dillon currently resides on the unceded land of the lək̓ʷəŋən speaking peoples, known as the Songhees, Esquimalt and W̱SÁNEĆ peoples.

Hilton King

My name is Hilton King I am a bi-cultural Indigenous social worker with a practice blend that is informed by euro-western and Aboriginal knowledge. I originally come from Wasauksing First Nation on the Georgian Bay. I hold a Masters Degree in Social Work and currently am employed with Dnaagdawenmag Binnoojiyag Child & Family Services as the Knowledge Keeper/Elder.

I carry the teachings of the land and I am a fire keeper who works with the sweat lodge and many other ceremonies. As I journey through this life, the cultural knowledge that was so freely passed on to me helps me stay balanced in life and as a helper, I offer the same support teachings to those who ask.

I have worked in Traditional Healing as a helper, Restorative Justice Coordinator, Mental Health worker and as a family support worker in Child Welfare, plus I am a skilled craftsman. Some of the traditional items I make are shakers, hand drums and

tignaakins (baby carriers) and I also offer these types of workshops.

Miigwech

Dr. Joanna Pierce

Dr. Joanna Pierce is an Associate Professor in the Faculty of Social Work, at the University of Northern British Columbia. She teaches in the areas of clinical social work, social work with northern remote communities, community development, and place-based practices. Her research is focused on place-based social work with northern remote communities and clinical practice in the north.

Dr. Judy White

Dr. Judy White is a registered social worker and Professor Emerita in the Faculty of Social Work, University of Regina. Her research and community work has focused on two areas: (1) the mental health and well-being of racialized diasporic peoples and newcomers (those who came in Canada as immigrants and refugees), and (2) food security and well-being of Indigenous and other peoples in Canada's north. Judy migrated to Canada from Trinidad and Tobago in the late 1980s.

Karmen Pearce

Karmen Pearce, MSW is a registered social worker in Yorkton SK. She provides counselling services at the Rapid Access Counselling Program at the Society for the Involvement of Good Neighbours (SIGN) and was a part of the research and development of walk-in counselling services in Yorkton and Kamsack.

Kristie Panchuk

Kristie Panchuk is a Clinical social worker (S.K.) with Ehrlo Counseling Services in Regina. She is also a sessional lecturer with the Faculty of Social Work, University of Regina. She was born and raised on Treaty 4 Territory, homelands of the nêhiyawak, Anihšināpēk, Dakota, Lakota, and Nakoda, and the homeland of the Métis/Michif Nation. As a therapist, Kristie takes a trauma informed and anti-oppressive approach to services and utilizes several evidence-based, theoretical frameworks that best suit the holistic needs of her clients. Kristie also worked in rural victim services and domestic violence victim services for several years prior to her work as a therapist. As such, she takes a special interest in intimate partner violence, safety planning with survivors and healing from interpersonal and intergeneration trauma.

Dr. Laurie Schmidt

Dr. Laurie Schmidt is a Population Health Promotion Practitioner with the Saskatchewan Health Authority and a Sessional Instructor at Athabasca University, Faculty of Health Disciplines. She teaches graduate courses in evidence-based practice in health care and leadership roles in health. Her research focusses on social interaction and physical activity among older adults in rural communities.

Melanie Abbott

Melanie Abbott has a Bachelor's of Social Work degree from the University of Calgary and a Master's of Social Work degree from the University of British Columbia (Okanagan). She is currently a Mental Health and Addictions consultant in Iqaluit, Nunavut. Throughout her career she has worked primarily in rural and/or remote communities, mostly in British Columbia, in the areas of child protection, at-risk youth, permanency planning, transgender care, and, for the past 9 years, specifically in mental health and addictions. Beginning during the Covid-19 pandemic she also started offering virtual therapy, thereby opening up the resources available to individuals unable to attend counselling otherwise.

Dr. Michelle Lam

Dr. Michelle Lam is the Director of Brandon University's Centre for Aboriginal and Rural Education Studies (BU CARES). She lives and works on Treaty 2 Territory, and is interested in innovative research methodologies, rural equity, and anti-racism. Her research program is focused on community-engaged work with rural educators, school divisions, and not-for-profit organizations to further equity for rural and Indigenous students.

Natalie Compagna

Natalie Compagna is a primary care social worker with Foundry Virtual BC which offers provincially available virtual services to youth aged 12-24 and their caregivers in British Columbia. She has a private practice and works as a TA for the University of

Waterloo's School of Social Work program. Natalie has 8 years of experience living and working in rural/northern Indigenous communities. During this time she has had the privilege of working with six different Nations across British Columbia and the Yukon.

Tavia McKinnon

Tavia McKinnon grew up on Treaty 1 Territory in Winnipeg, Manitoba and received her Bachelor of Social Work at Université de Saint-Boniface. She is currently a Master of Social Work student at University of Northern British Columbia on the unceded traditional territory of Lheidli T'enneh First Nation. Her MSW thesis research explores youth relationships with land and place in the Nechako watershed in north-central B.C.

Dr. Vivian R Ramsden

Dr. Vivian R Ramsden, a Registered Nurse, is a Professor & Director of the Research Division in the Department of Academic Family Medicine, College of Medicine, University of Saskatchewan. She teaches in the areas of clinical research methods and family medicine/primary care research. As a participatory researcher, she is a passionate advocate for authentic engagement, co-creation and transformative action research which involves strategies to engage individuals and communities in identifying and addressing locally relevant issues that impact health and wellness. She is an Honorary Member of the College of Family Physicians of Canada and a Fellow in the Canadian Academy of Health Sciences.

Dr. Wanda Seidlikoski Yurach

Dr. Wanda Seidlikoski Yurach is a registered social worker and has been employed as a mental health therapist in northern remote Saskatchewan communities for over 16 years. She has also taught for the University of Regina as a Sessional Lecturer since 2003. Her areas of interest include northern remote mental health supports, social worker well-being, community-based participatory research and working with communities to develop land-based mental health/well-being supports for youth and adults.

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Braiding Trauma-and-Violence Informed Care Practice Guidelines into Competencies for Social Workers working in Rural and Remote Locations

6

Carrie LaVallie and Wanda Seidlikoski Yurach

Trauma-and-violence informed care (TVIC) guidelines and practice policies in human service work impress upon the need to include historical and cultural principles. A culturally comprehensive approach for TVIC is not available for many mental-health providers working in rural, remote, and northern locations in Canada, including social workers. Canada's colonial legacy created experiences for Indigenous peoples that western[1]-based approaches/practices often overlook and/or cause traumatic triggering. Acknowledging the historical impact colonization has on Indigenous peoples' health, and understanding the lingering effects of intergenerational trauma, provides key insights into the health and wellness of rural and remotely located Indigenous peoples. Being trauma-and-violence informed "is not about 'treating' trauma," it is about focusing on enhancing safety, control, and resilience (Government of Canada, 2018, p. 3); acknowledging cultural contexts of understanding and healing; and in turn creating psychological safety for both the client and the provider. This chapter braids a trauma-and-violence informed framework and the Indigenous Cultural Responsiveness Framework (Sasakamoose et al., 2017) with social-work practice competencies, creating a more comprehensive approach for social workers working with Indigenous populations in rural and remote communities.

Cultural understandings of healing engage figurative language to explain health concepts. Creating relationships with clients by reducing triggering communication and using a common language can create a trusting space for sharing. Braiding TVIC guidelines, Indigenous Cultural Responsiveness Framework (ICRF), with social-work practice competencies, explores how we explain the same experiences through our beliefs and approaches that support healing. Current healing systems rely on dominant western perspectives; therefore, to create effective decolonized services, social workers need to incorporate treatment and intervention approaches that reflect the worldview of the client. Decolonization is the process of balancing population needs and countering western dominance. Decolonizing the dominant western perspective for trauma-and-violence informed care means prioritizing local understandings of health and harmonizing them with proven western-based methods, within the Indigenous Cultural Responsiveness Framework. This chapter uses the metaphor of a braid to illustrate how social workers blend trauma-and-violence universal precautions that are culturally suitable into their practice. The first section introduces you to TVIC concepts and the second introduces you to the Indigenous cultural responsiveness theory. The third section explains how social workers can harmonize, blend, or braid these three approaches into a wholistic, culturally-suitable healing approach for working with clients who may have experienced violence or trauma. By the end of this chapter, you should be able to describe the principles of trauma-and-violence informed care and the Indigenous Cultural Responsiveness Framework and then use real-world examples to apply them to social work practice competencies for working in rural or remote locations.

Learning Objectives

By the end of this chapter you will have had the opportunity to:

- Identify power imbalances in rural and remote locations where social workers practice.
- Describe principles of a trauma-and-violence informed framework (TVI).
- Discuss a culturally suitable practice when working with rural and remote clients.
- Critically reflect on alignment of data collection method using universal trauma precautions.
- Apply concepts of Culturally Responsive trauma-and-violence informed care to social work practice.

Figure 1

Braided Sweetgrass



Note. Photo Courtesy Dr. Carrie LaVallie, 2021.

Braid 1 Trauma-and-Violence Informed Care

Trauma-and-violence informed approaches (TVIA) is a way of being that reflects a caring, ethically-based relationship, recognizing "the connection between violence, trauma, negative health outcomes and behaviours" (Government of Canada, 2018, p. 2). Trauma-informed approaches in social work practice presume that clients seeking services may have experienced trauma; therefore, care providers assess for signs/symptoms of trauma and the overall impact on their client's lived experience. The Government of Canada encourages inclusion of "violence" into the term "trauma-informed" to represent the connection of violence with trauma (2018). Addressing the effects of trauma includes recognizing that violence might have happened in the past or is ongoing and may cause long term-effects (Government of Canada, 2018).

Social work policy and practice should include efforts to understand how trauma and violence impact people's lives and behaviours. This awareness supports creating emotionally and physically safe environments; fostering opportunities for choice, collaboration, and connection; and providing strength-based and capacity-building approaches to client care. **Trauma-and-violence informed social work practice competencies** are evidence-informed methods and interventions that include the impact of trauma and violence on one's life while targeting specific physical, mental, and spiritual health issues seen as overall well-being. Social workers seeking to provide trauma-and-violence-informed (TVI) practice competencies need to employ the following four principles as outlined by Health Canada (Government of Canada, 2018) and are used as guiding principles in this chapter:

1. Practitioners understand that trauma and violence impact on peoples' lives and behaviours. Knowing "exactly" what happened to the client is not as important. as knowing that when someone reacts in an unexpected way, the social worker can reflect upon the possible traumatic or violent incidents that may have been experienced by the person and lead with empathy and understanding.
2. Fostering authentic connection and communication in non-judgmental ways helps to build trust and provides consistent expectations to the client. Communication through clear expectations and non-judgement language fosters trust between the practitioner and client, thus resulting in more honest sharing of the client's lived experience. Honest sharing gives the social worker more information from which to create effective, client-based intervention and treatment options.
3. Trauma research and effective treatment is rapidly emerging. To stay on top of evidence-supported methods, organizations and systems can deliver ongoing training and professional development events to foster opportunities for choice, collaboration, and connection with the clients.
4. Understanding that dominant service systems often oppress, marginalize, and dismiss trauma-impacted people helps the social worker to anticipate client reactions and needs.

By utilizing trauma-and-violence informed practice competencies and principles, the social worker *becomes* the intervention approach. Creating a healing environment that includes a safe trusting manner will further improve the effectiveness of the practitioner as the intervention. Unsettling physical or psychological experiences (called a **trigger)** may cause an unexpected response. To help prevent or lessen triggers that may arise from trauma experiences, it is paramount that service providers set up an emotionally and physically safe environment, using a non-judgmental attitude, offering choice and collaboration, and anticipating client needs. Critical self-reflection, along with clear expectations for the provider, informed by the principles of trauma-and-violence informed care (TVIC), will help professionals to employ strength-based, capacity-building approaches to support favorable coping responses and resilience.

Trauma

Trauma is the lingering memory, either psychologically or physiologically (or both), of a disruptive event that impacts a person's sense of safety and control; and is defined as "a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual wellbeing" (SAMHSA, 2014, p. 4). When the body's natural defence responses are unable to complete the process of protection or reaction, or supportive resources are not in place to aid feelings of safety and connection, a traumatic response may develop (Levine, 2010): "Traumatized people are fragmented and disembodied. The constriction of feeling obliterates shade and texture, turning everything into good or bad, black or white, for us or against us. It is the unspoken hell of traumatization" (Levine, 2010, p. 355).

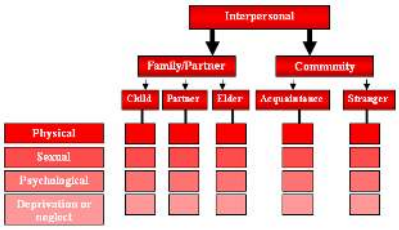
Once thought to affect only people exposed to natural disasters or war situations, the concept of trauma has evolved to include explanation from many theories such as developmental, childhood, incident-based, intergenerational, medical, and complex. Intergenerational trauma "is passed on through parental/institutional patterning from one generation to the next, as well as being transmitted through blood lines" (Linklater, 2011, p. 20). Society's stigmas about one's gender, race, sexual orientation, ability, and/or culture disproportionately increase one's experiences of, and effects of, trauma. Lingering effects on trauma-impacted people may present as post-traumatic stress disorder (PTSD) which includes a comprehensive cluster of symptoms profound enough to interfere with one's family and social relationships, work, and well-being (American Psychiatric Association, 2013).

Violence

In working with trauma-impacted people, social workers recognize the need to implement an understanding of violence into policies and practice. Violence might be recurring or an isolated incident that has an overwhelming impact on people's lives. Incidents of violence can be overt, for example, a physical assault; subtle (blocking women's reproductive rights); or implied, such as systemic racism. The World Health Organization's Violence Prevention Alliance (VPA, 2021) defines **violence** as, "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (para. 2). The VPA (2021, para. 3) classifies four modes of violence: physical, sexual, psychological attack, and deprivation; and three sub-types: self-directed, interpersonal, and collective. Self-directed violence is injurious actions initiated against oneself such as self-harm or suicide. Violence directed toward another person is coined as interpersonal violence (see figure 2 Typology of Interpersonal Violence). Child, partner, or Elder maltreatment/neglect, are expressions of family/partner violence; whereas "youth violence; assault by strangers; violence related to property crimes; and violence in workplaces and other institutions" are forms of community violence (VPA, 2021, para. 4). Violence within 2SLGBTQ+ relationships is often stigmatized and ignored in heteronormative programming. Social, political, and economic violence such as social exclusion, structural racism, and epistemic racism (Reading, 2013) are examples of collective violence (VPA, 2021).

Figure 2

Typology of Interpersonal Violence



(Source: World Health Organization's Violence Prevention Alliance, 2021)

Religion or language once organized people into social class structures (Reading, 2013). However, colonization replaced religion and language rankings with race classifications misappropriated as a scientific measure for human characteristics. Racial classifications applied biological understandings to socially-constructed concepts that used scientific evidence to generate beliefs regarding intelligence, evolution, and violence. *Relational racism* is the day-to-day overt acts of violence that BIPOC (Black, Indigenous, People of Colour) and 2SLGBTQ+ people experience, such as being followed in a store, called names, or physically attacked because of skin colour or sexual/gender expression. Government acts and policies established covert forms of *systemic racism*, such as social exclusion. *Social exclusion* is an act of community violence (Raphael, 2020).

People are racialized through physical and/or social isolation policies resulting in unfair distribution of housing, healthcare, education, and employment (Jacklin & Warry, 2012). For example, 2SLGBTQ+ leaving violent relationships often encounter exclusion from shelters because they do not fit into the female heterosexual intimate partner violence survivor stereotype (Mortimer et al, 2019). Indigenous peoples in Canada experience social isolation through the rural and remote location of reserves, and at one time Indigenous peoples held no voting rights (Raphael, 2020). Many Indigenous communities experience poor quality of housing or infrastructure; access to clean drinking water may be an issue even within 50 kilometres of a town or city (Government of Canada, 2021).

Epistemic racism, preferring one form of cultural knowledge over another, often goes unacknowledged (Reading, 2013). *Structural racism* builds from epistemic racism believing that western knowledge systems are superior. Government deeds create inequitable laws, policies, rules, and regulations; these prevent opportunities to contribute to the economy, develop resources, and participate in political endeavours. Knowledge bias creates oppressive and discriminatory practices. The practices then become structural systems that support dominance for settlers' perspectives and needs, without Indigenous peoples' input. Examples include reserve size, health treatment options, and legal approaches and outcomes.

Reading (2013) explains that *embodied racism* is the somatic reaction to covert forms of racism. Indigenous peoples experience the many forms of racial violence that go unaddressed and over time create lingering trauma responses. Colonization changes the brain's neural pathways and neurodecolonization must take place within the colonized person to generate helpful, empowering thoughts (Yellow Bird, 2013). Michael Yellow Bird, a social worker, developed neurodecolonization theory by converging Indigenous-healing and Western-based practices (Yellow Bird, 2013). Neurodecolonization theory is the process of reconciling the effects of colonization through mindfulness practice and then seeking united solutions to issues of well-being. Before reconciliation can take place, one must decolonize one's mind and overcome negative feelings created by structural oppression (maintained through colonialism), by exercising neurodecolonization (Yellow Bird, 2013). Social workers can also decolonize their own minds by challenging power imbalances, incorporating a mindfulness practice, and countering the colonized mind by exposing forms of racism and racial structures.

Social workers who keep in their awareness that trauma impacts might be the result of violence, and that the interventions available are based on a western-dominant, colonized system, can then challenge the impulse to blame/judge the client's actions as moral failings. Clients' decisions or actions might be based on a trauma response that stemmed from one or more violent incidents/experiences with colonial and patriarchal structures. For example, children who witnessed intimate-partner violence between their caregivers may develop childhood-trauma symptoms such as heightened anxiety around others. The child may feel highly anxious when in the social worker's presence and as a result might respond with defiance or hostility. Understanding that a child may feel unsafe in the presence of others will help to inform a social worker to create an environment that supports the child to feel safe and in control. If a teenager presents with self-harming behaviour (such as cutting), the social worker can hold in their awareness that incidents of sexual assault or abuse may increase the likelihood of self-harming behaviour (Madge et. al., 2011). Leading with a trauma-and-violence informed lens will support social workers in seeing the self-harming behaviour as a possible coping mechanism as opposed to attention-seeking performance. The act of immediately assuming negative stereotypes about Indigenous peoples may be explained by understanding that the first settlers generated negative stereotypes of Indigenous people as defiant, hostile, and attention-seeking and thus situated Indigenous peoples in the position of needing control and management. In contrast, trauma-and-violence informed care (TVIC) observes that client behaviour arises from disrupting or overwhelming experiences based in colonial messaging and structures, which in turn requires a safe, caring, non-judgmental environment.

To uncover covert violent practices of systemic racism, social workers can critically self-reflect upon their own colonial history, and/or position of privilege, and/or assimilation/oppressive practices. For example, clients who themselves have faced negative residential school experiences, or their family members, may unknowingly hold mistrust of government institutions in their physiological or psychological systems (Truth and Reconciliation Commission [TRC], 2012). It is important for all social workers to develop trauma-informed policies and practices, and attend training to mitigate potential harms to clients. Experiences of discrimination and other forms of violence are prominent amongst people who do not fit into the white, male, heterosexual, able-body, categories. Abuse based on gender or sexuality; or spiritual; emotional, financial, psychological or physical control negatively influences decisions and outcomes about well-being. Thus, to effectively practice trauma-and-violence informed care, it is important for social workers to contextualize their client's behaviour, versus viewing it as a pathology or as a moral failing.

Universal Trauma Precautions

A social work trauma-and-violence informed care practice goal is to minimize harm to clients (Canadian Association of Social Workers [CASW], 2005; Saskatchewan Association of Social Workers [SASW], 2020). Embedding universal trauma-and-violence precautions into policies and approaches for work with all people helps to create a common delivery method for helpers to provide consistent services to lessen the potential to unintentionally re-traumatize the client. Broadening the definition of trauma supports social workers to understand trauma as "inextricably linked to systems of power and oppression" (Becker-Belease, 2017, pp. 131-132) versus understanding trauma as an "individual pathology." Trauma-informed methods that question the "status quo" broaden a social worker's approach to include the elimination of inequality and racism that cause harm/trauma. Trauma-and-violence informed care helps survivors to reclaim their power, by considering "client's sensitivity to issues of trust, power, and stigma" (Becker-Belease, 2017, pp. 134-136). As follows, to mitigate potential barriers to care and better meet the unique needs of trauma-impacted people, rural/remote social workers should be encouraged to incorporate universal trauma-and-violence informed approaches.

Trauma-impacted people often feel terror, shame, helplessness, and powerlessness (Canadian Centre on Substance Abuse, 2014). To reduce negative experiences and increase safety and control, rural and remote social workers are invited to integrate universal trauma-and-violence precautions by assuming every person they work with may have experienced trauma and/or violence, and therefore do not have to retell their story and be potentially retraumatized. Social workers can lessen the potential triggers that occur in telling one's story and in turn can increase the client's sense of safety, self-determination, and resilience. Trauma-and-violence informed practice is a harm-reduction approach because the social worker minimizes potential negative experiences for people living with trauma. The outcome from using universal trauma precautions is a reduction in client blame and pathologizing of client behaviours, and is essential to reducing harm when working with rural and remote clients.

Examples

Critical Thinking Question #1

- You begin planning to work with your first client. How might you prepare to discuss incidents of trauma and violence with your client. What might prevent you from broaching the subject with your client? What experiences might they have encountered that are trauma and violence related? When would you ask for help if you encounter difficulties in working with your client about trauma and violence?

Mitigating Secondary Trauma

Secondary trauma results from providers listening to the troubling details of client trauma stories (Bishop & Schmidt, 2011; Harrison & Westwood, 2009; Hensel et al., 2015; O'Neill, 2010), and is also referred to as vicarious trauma or secondary traumatic stress (Elwood et al., 2011). Secondary traumatic stress is "the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1993a in Figley, 1995, p. 7); it has psychological characteristics resembling post-traumatic stress disorder (Baird & Kracen, 2006). Alternatively, vicarious trauma is the "harmful changes that occur in professionals' view of themselves, others, and the world, as a result of exposure to the graphic and/or traumatic material of their clients" (Baird & Kracen, 2006, p. 181).

Social workers most impacted by secondary trauma are newer workers with high trauma caseloads, as well as a personal history of trauma and stressors outside of work (Dagan et al., 2015; Devilly et al., 2009). Social workers in remote locations in Canada reported that isolation and dual relationships/boundary challenges negatively impacted their well-being. They also conveyed limited access to clinical supervision, colleagues, and client supports led to poor mental health (O'Neill, 2010; Seidlikoski Yurach, 2021). Signs of experiencing secondary trauma are increased levels of arousal (hypervigilance), intrusion (negative thoughts/images), and avoidance (places/people) (Bride et al., 2004).

To lessen the impacts of secondary trauma on social workers, organizations acknowledge the implications of client trauma stories on rural and remote providers including how it might impede their ability to carry out daily activities (O'Neill, 2010). Secondary trauma is a valid concern for service providers and "the key to successfully working with trauma victims is understanding secondary trauma and the risks associated with hearing traumatic material and finding ways to process and cope with it" (Hesse, 2002, p. 308). Taking care of oneself is paramount in rural/remote social work practice. Therefore, social workers should also incorporate continuing education and professional development that includes trauma-and-violence informed theories and information about Canada's colonial legacy as part of their practice. Doing so may help reduce incidents of secondary trauma and provide social workers with a clearer understanding of the trauma passed on to the population with whom they are working.

Trauma-informed practice includes taking care of the needs of practitioners and helpers. Benedict (2015, p. 18) comments that "…the healing journey and spirit of the helper is just as important as that of the one seeking help…" and "in order to help in a good way with a good mind, helpers need to be cared for and care for ourselves." To incorporate a trauma-informed framework, the social worker must understand that they are participating in their own healing journey. Working with trauma-impacted people means the people providing the service are also tending to their own well-being in a holistic way (Wieman, 2009). For example, Somatic Experiencing® is a neurobiological approach to releasing traumatic shock from disrupting events. Peter Levine (2010) created this framework, as well as specific clinical tools, to support trauma healing. Some professionals working with trauma-impacted people feel they have limited control over their positions; thus, they might attempt to control others as a management strategy. Incorporating Somatic Experiencing® practices helps to regulate the social worker's nervous system and in turn creates an environment of safety, self-determination, and resilience for the client. Somatic Experiencing® is an approach that is not taught within the social work practice. Social workers interested in using this approach may access the information through books or take specific training around the world through different venues. Continuing professional development such as workshops that focus on healing oneself is as important as social work practice-based information.

When participating in one's own healing journey, Elder teachings inform us that for some, an Indigenous belief is that reciprocity is paramount in healing; in other words, we are all healing together (LaVallie, 2019). Institutions, particularly those in rural/remote locations, can create supportive healing work environments to mitigate/prevent secondary trauma for workers including: access to regular debriefings and clinical supervision, and open discussions amongst colleagues about the stressors of social work (in person or remotely) as an important daily/weekly routine. Although rural/remote and northern locations may have limited access to supports to lessen secondary trauma such as professional colleagues, interdisciplinary teams (Collins & Long, 2003) and/or "a community of practice" (Wenger & Snyder, 2000), these supports are readily available online or by phone. Working on their own healing journey within a supportive work environment can create a strong foundation for social workers to reduce and/or prevent the effects of secondary trauma.

This section identified the first strand of the braid: *social workers approaching their clients with a universal trauma precaution lens*. Social workers endeavor to assume that all clients may have experienced trauma that includes some form of violence encounter and thus lead with a non-judgmental approach. As well, following the principles of offering choice, a safe space (physically and psychologically), collaboration, and focusing on the client's strengths, the social worker is the first intervention when employing trauma-and-violence informed care. The client may not feel like a whole person due to the trauma; therefore, resourcing the client's strengths helps to lessen their trauma response. Remember that the social worker does not need to know the client's whole story,

only that an incident impacted the client and that they may display an unexpected response due to a physical or psychological trigger. All social workers may be at risk of experiencing secondary trauma. To prevent this negative impact, social workers should attend professional development opportunities regarding trauma-and-violence informed practice and opportunities that support healing one's self. In addition, social workers must work to decolonize the institutions and organizations that continue to oppress and marginalize clients. To do this, they first decolonize their own minds through neurodecolonization methods and then endeavor to incorporate culturally suitable approaches. The next section explores how social workers can braid in *decolonizing culturally suitable approaches* to strengthen the human services they offer to clients.

Braid 2 Indigenous Cultural Responsiveness Framework

Although, as discussed in the previous section, social-work professionals must be trauma-and-violence informed, questions can still arise regarding the cultural suitability of western-developed trauma-and-violence informed approaches "based on adherence to Westernized culture" (Knowlton & Lafavor, 2021, p. 1). Eighty-eight percent of practitioners surveyed, who work with American Indigenous trauma-impacted peoples, believed there was a "lack of inclusivity of culturally-informed approaches with current" evidence-based practices (Knowlton & Lafavor, 2021, p. 11). Evidence-based practice has "long been criticized for its ethnocentrism in which outcomes from empirical studies are thought to generalize across a wide range of populations" (Knowlton & Lafavor, 2021, p. 16). Ethnocentrism is the practice of comparing one's own cultural standards and beliefs against another while holding in their awareness the superiority of their own culture. For example, western settler understandings of how things are done and what one should value took precedence over other ways of knowing. What was "proven" as scientific was really a narrow understanding of what was true for western-based people. Canada's colonial legacy created a false belief that non-western-based science, ability, intellect, and cultural practices were unevolved and without merit. Leaders, at that time, set policies in place to treat Indigenous peoples and communities as inferior and as needing to be controlled (for example the *Indian Act*, the Indian Agent's role, and the use of residential schools). Decolonizing is the process of examining colonial systems and then creating a new way of moving forward that honours the ways of knowing and being of the peoples who were colonized (Linklater, 2014).

Indigenous communities experience continued chaos due to "oppression, colonization, and residential school history" and the resulting stress is associated with "depression, anxiety, low self-esteem, and difficulty expressing emotions" (Brave Heart, 2004 as cited in Linklater, 2011, p. 34). There are links between substance abuse and mental health issues stemming from traumatic memories resulting from failed assimilation processes (Health Canada, 2011). Indigenous-based teachings, activities, and practices include methods that are helpful for trauma-impacted people (LaVallie, 2019; Linklater, 2011; Sasakamoose et al., 2017). Cultural trauma-informed care "acknowledges and teaches about the Indigenous-specific effects of colonial policies and how they are linked to historic and current medical services for Indigenous people" (Indigenous Health Working Group, 2016, p. 5). Therefore, key approaches to address well-being must include understanding Canada's colonial history, providing culturally-safe services, and valuing cultural knowledge (Health Canada, 2015). As such, social work services ought to consist of culturally-suitable and trauma-informed treatment and supports. The following section will explain how to employ culturally-suitable approaches by understanding cultural safety, using reflexivity in social work practice, and implementing an Indigenous Cultural Responsiveness Framework. These three factors create the second braid in the trauma-and-violence informed, culturally-suitable, social work practice braid.

Cultural Safety

Rural and remote based social workers find it important to provide services that demonstrate cultural understanding, respect, and inclusion (CASW, 2005, p. 4). Those working with Indigenous people must be aware of their unique needs to provide culturally-safe services (Health Canada, 2015). Cultural safety encourages providers to recognize power imbalances and reflect on their biases that support discrimination. Discrimination is "Treating people unfavourably or holding negative or prejudicial attitudes based on discernable differences or stereotypes (AASW, 1999)" (as cited in CASW, 2005, p. 34). Cultural safety goes beyond refraining from "making assumptions based on people's appearance or presumed ethnicity" (Government of Canada, 2018, p. 9), as it includes challenging power imbalances (unequal influence over self-determination or economy) and changing practice approaches. Cultural safety involves social workers acknowledging that service users decide "whether the professional relationship feels culturally safe" (De & Richardson, 2008, p. 39). Therefore, even if a social worker believes they are presenting in a culturally-safe way, if a service user indicates otherwise, social workers must be open to learning from the teachings/critique provided by the service user. Ultimately, cultural safety is the practice of supporting the client to express their culture.

Institutional barriers that inhibit Indigenous peoples from receiving culturally-safe care include limited understandings of Canada's colonial history and assimilation policies, and a lack of respect for Indigenous ways of knowing and healing (First Nations, Métis, and Inuit Advisory committee of the Cultural Safety committee for the Cultural Safety Working Group [CSWG], 2013, p. 8). The CSWG (2013) states that "To be effective, care providers need to understand how the burden of unresolved personal and historical losses carried by many recipients of care may shape present behaviour" (p. 11). For people "who are attempting to work through other traumatic experiences, or who are dealing with severe psychological pain and addictions, understanding the dynamics and impact of history can be a part of the therapeutic healing process" (Aboriginal Healing Foundation [AHF], 2006, p. 42). Agencies and helping professionals are, therefore, encouraged to "participate in cultural competence and understanding as it relates to the Indigenous populations they serve" (Klinic Community Health Centre, 2013, p. 51). Failing to do so can potentially cause additional distress for individuals seeking supports.

The Canadian Association of Social Workers (CASW, 2005) adopted *Guidelines for Ethical Practice* outlining both cultural awareness and sensitivity. Through the guidelines, social workers are invited to understand culture, acknowledge diversity, respect the impact of their own heritage, and be aware of the customs and languages of their clients (CASW, 2005, p. 4). The Saskatchewan Association of Social Workers (SASW, 2020) expands the CASW (2005) guidelines, and asks for social workers to "strive to obtain a working knowledge and understanding of the impact that their own heritage, values, beliefs, and preferences can have on one's practice and on clients whose background and values may be different from their own" (SASW, 2020, p. 11). To be compassionate, to build relationships, and to understand others, one must engage in a process of critical self-reflection to understand one's self. To work in rural or remote communities, social workers must reflect on their positionality in colonial structures and take on a broader perspective based on openness and curiosity to another's culture such as cultural humility (coined by Tervalon & Murray-Garcia, 1998). Cultural safety, therefore, needs to include cultural awareness, sensitivity, competence, and cultural humility.

Examples

Critical Thinking Activity #2

- A school located in a remote community hires you as the school's liaison social worker. The principal asks you to increase parent attendance at parent teacher interviews. How would you braid together a trauma-and-violence informed approach with cultural responsiveness to complete this task? What information do you need to prepare the braids? Who would you enlist to support your work? Where would you start in creating relationships with the students, the school, the parents, and the community?

Reflexivity

A decolonizing, trauma-and-violence informed approach in social work practice involves a process of critical self-reflection to develop innovative approaches to healing (Linklater, 2011). Reaching out for help, by trauma-impacted people, depends on several factors including availability of services, perceived 'victim blaming,' and a lack of trauma-informed responses by practitioners (Schreiber et al., 2010). Reflexivity is a contemplative practice that invites social workers to explore their experiences, challenge their biases, and discover how they have changed because of the process (LaVallie, 2019). Schreiber et al. (2010) argue that "Public attitudes about interpersonal violence and mental health play an important part in shaping the social environment in which the [trauma-impacted people] and the help-providers are embedded" (para. 18). We need more trauma-and-violence informed and trained professionals, who are knowledgeable about agencies in order to refer clients and to incorporate a reflexive contemplation of the social worker's role in supporting healing. Strategies produced by the social worker represent a combined way of knowing that is not returning to the "time before" but creating a new way forward (LaVallie, 2019). Employing trauma-and-violence informed measures means embracing local healing practices or approaches. Braiding cultural responsiveness and trauma-and-violence informed care frameworks into social work practice competencies relies heavily on institutions, which must honour and provide opportunities for Indigenous-based ways of healing. Only with institutional support will social workers be able to harmonize with clients so that culturally suitable and trauma-and-violence information care practices can be used. Most importantly, social workers and clients should feel free to employ culturally-suitable methods that match local customs and ways of healing.

Social workers employing Indigenous cultural responsiveness need to start by examining their own ethnocentrism. They do this by building a relationship with people who are "not like them." Relationship building honours five elements: respect, reciprocity, relevance, responsibility, and reflexivity. Sasakamoose (as cited in Evans et al., 2020), when discussing research practices, states that "Kirkness and Barnhardt (1991) have identified the "4 Rs" for developing research procedures in an Indigenous context and Kovach (2010) identified a fifth" (p. 65), which is reflexivity. Reflexivity moves past simple reflection, and toward examining how the practitioner was changed because of the work done with the client, together in a relationship of a healing. To deepen the reflexivity process, the social worker uses cultural catalysts to invite relationships to develop with the client, community, environment, and ethos, which then support co-constructing new knowledge for healing (LaVallie, 2019). Cultural Catalysts and local healing practices are cultural activities, prayers, smudges, drumming, ceremonies, hand-building activities, languages, sweats, dances, stories, and land-based activities based on local knowledge and regional materials. To employ reflexivity, social workers are invited to acknowledge the relationship they have with the client and/or

community, decolonize practice competencies and institutional policies to mitigate triggers and equalize power imbalances, and incorporate local figurative language and ways of knowing and doing.

People living with trauma will often use more general professional resources to connect to mental health services (Stokes et al., 2017), such as their family doctor, nurse, social worker, or teacher (Ansara & Hindin, 2010; Schreiber et al., 2010; Woodtli, 2000). Although many professional practice guidelines talk about cultural safety and trauma-and-violence informed (TVIC) care as incorporating historical and cultural understandings, they do not include examples. TVIC guidelines, therefore, can appear vague, without clear examples of how to implement the theory (Stokes et al., 2017). Often missing from the guidelines is a non-western perspective—a perspective whereby an Indigenous culture and ways of knowing are incorporated into the trauma-healing experience. As previously discussed, western settlers created education systems and health institutions based on western ways of knowing and doing. Non-western healing approaches were devalued and left out of trauma-and-violence treatment approaches based on racist notions of inferiority and superiority.

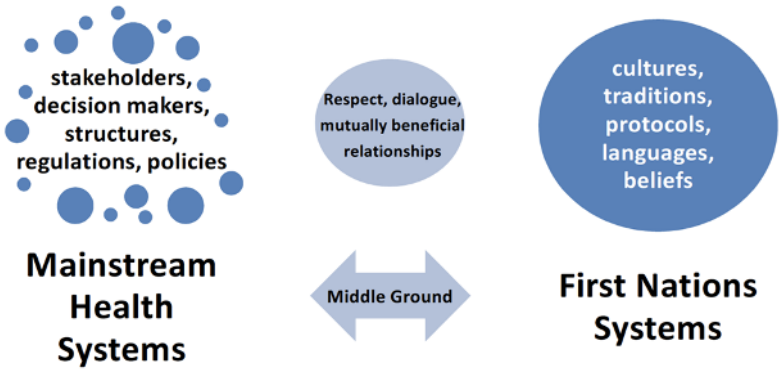
Colonial systems (including learning institutions) expect helping professionals to understand the populations that they work with, but do not always give professionals adequate culturally-responsive resources. Even helping professionals that are of the same culture as their clients might struggle to incorporate local customs and ways of knowing because institutional barriers prevent adapting suitable assessment and treatment approaches. Social work practice competencies must include a trauma-and-violence informed framework along with an Indigenous Cultural Responsiveness Framework to develop an overall comprehensive approach to work effectively in rural and remote communities. Culturally-suitable approaches can be met by being culturally responsive. Therefore, the next section will explain how cultural responsiveness, developed through a grass roots effort, guides western institutions in providing culturally-suitable practice options.

Indigenous Cultural Responsiveness Framework

The Indigenous Cultural Responsiveness Framework (ICRF; Federation of Saskatchewan Indian Nations [FSIN], 2013) is "about restoring and enhancing First Nations own health systems" (p. 7) whereby "the two systems could come together as equals to work together in a way that would be to the benefit of all" (p. 6; see figure 3), Thus, cultural responsiveness is a decolonizing approach to improve health and social-based systems by honouring Indigenous ways of knowing and being. The Indigenous Cultural Responsiveness Theory "is a model created and owned by First Nations peoples living within Saskatchewan's borders" (Sasakamoose et al., 2017, p. 1). This theory guides the Indigenous Cultural Responsiveness Framework and provides principles that "can be locally adapted and applied" (Sasakamoose et al., 2017, p. 1) to communities servicing First Nations people. Principles in decolonizing approaches must be trauma-informed, strengths-based, community-engaged, and spiritually-grounded (Snowshoe & Starblanket, 2016). Cultural Responsiveness positions Indigenous systems alongside Western-based systems with a middle ground containing ethical space (Ermine, 2007), two-eyed seeing (coined by Marshall et al., 2015), and harmonizing ways of knowing (LaVallie & Sasakamoose, 2016). Ethical space is created and considered sacred (Sasakamoose et al., 2017). Within this middle ground, social workers interact with rural and remote populations to create culturally-suitable care and approaches. Employing Indigenous Cultural Responsiveness Framework engages many of the Truth and Reconciliation Commission of Canada's (TRC, 2015) calls to action. As part of this process, non-Indigenous partners and allies are encouraged to examine their values, skills, and attitudes about cultural competence and work toward reconciliation.

Figure 3

Indigenous Cultural Responsiveness Framework



(Source: Federation of Saskatchewan Indian Nations, 2013, p.9.)

The second braid in the trauma-and-violence informed, culturally-suitable, social work practice braid recognizes power imbalances and asks the social worker to reflect on their own biases that support discrimination. This section explained how to employ culturally-suitable approaches by understanding cultural safety, using reflexivity in social work practice, and implementing an Indigenous Cultural Responsiveness Framework. The social worker incorporates cultural awareness, sensitivity, competence, humility, and safety to provide a culturally-competent practice. Additionally, social workers are invited to reflect on their experiences with the clients. This reflection includes providing trauma-and-violence informed care, challenging discriminating thinking, and discovering how they and their practice have changed because of the process. The first two braids offered theory to inform practice. The next section introduces the third braid that weaves social work practice competencies with the theories.

Braid 3 Practice Competencies

Incorporating trauma-and-violence informed care (TVIC) while acknowledging the negative effects of a colonial legacy, providing culturally-safe services, and valuing cultural understandings works to dismantle ethnocentrism and covert racism. Social workers are invited to decolonize their approaches with rural and remote peoples by braiding frameworks that honour the lived experiences of trauma-impacted Indigenous persons. Braiding frameworks creates a stronger approach than using one strand alone. Social workers are encouraged to employ trauma-and-violence informed universal precautions to mitigate triggers by creating a safe space, starting their own healing journey, and employing Indigenous cultural responsiveness into services. This section offers practical applications to rural/remote social work competencies through the micro-level that involves working directly with individuals or families.

Creating Safe Space at the Micro-level

Social workers have a duty to provide trauma-and-violence informed care (TVI); this means prioritizing safety, control, and choice. Social workers braid a TVI framework strand and an Indigenous Cultural Responsiveness Framework (ICRF) strand by learning about these two theories. They then begin to braid in the third strand of practice competency by starting their own healing journey and creating a safe space.

A safe physical and communicative space supports clients to share their experiences (Moss et al., 2012). To create a safe space, a social worker follows local customs to attain the services of, and collaborate with, an Indigenous or local Knowledge Keeper within the community the social worker offers services. Together they consider what would make the space feel comfortable and inviting for that community's members. This resource person can guide the social worker in understanding what the client might need prior to the appointment. They can assist with information about barriers to parking, transportation, daycare, family obligations, or employment restrictions related to attending. Thus, creating a safe space starts with reducing barriers for clients to attend the appointment. The social worker then does a walk-through, with the Knowledge Keeper, starting with entering the building, going to the office or room, running through a mock session, and then leaving the location. The Knowledge Keeper will offer suggestions for visual identifiers and spaces that encourage safety, control, and choice. Local artwork, local language speakers, and access to food, beverages, and bathroom facilities (some clients may not have eaten before attending the appointment or had a long way to travel) encourage a sense of connection and acknowledgement of the client's worldview. Walking through the space and employing universal trauma-and-violence protocols with Indigenous Cultural Responsiveness Framework will help to lessen trauma-inducing

incidents. Social workers can also apply this approach to non-Indigenous peoples in rural and remote areas by enlisting the services of a local community member to aid with the walk-through, identify barriers to attending and ways to create a safe space.

Examples

Critical Thinking Activity #3

- Imagine that you are entering a building that you have not been in before. Notice how you feel before you open the door. What might you want to know before entering? Whom are you meeting, where are they located, is there a waiting room with other people? Are you able to walk right in or do you need someone to let you in? These are common questions that most people have before entering a new place. Now imagine if the place that you are going into is designed in a way that makes you feel unsafe. How does this affect the way you are feeling? Do you still want to enter the building? Should places be designed to make you 'feel safe'?

Assessment

Trauma-impacted people endure memories, sensations, emotions, and/or images connected to the dysregulating event that impacts their ability to make a connection with others or to respond suitably. Social workers can hold in their awareness that, for some clients, making it to the appointment takes a lot of effort. Social worker interactions with trauma-impacted people may inadvertently re-traumatize or trigger the client through touch, innuendoes, interpretation of behaviours, and/or forceful or demanding language (Government of Canada, 2018). Approaching a person from behind or touching a person without permission (even on the shoulder) may activate an autonomic nervous response. The person may startle or lash out for seemingly no reason. A non-judgmental attitude invites the client to share their concerns about, or barriers to, attending the appointment.

Social workers use empathy, respect, immediacy, genuineness, conciseness, clarity, listening, and non-verbal behaviours to communicate (Beesley et al., 2018). However, they often overlook their own language when they think about working with clients. One's intention behind communication is evident in how and what one says. Clients can interpret underlying biases, judgements, and assumptions held by the helping professional, which may result in the client feeling unsafe.

Trauma-and-violence informed assessments lessens triggering language, supports self-determination, and focuses on strengths. Social workers may regularly be conducting intake assessments and/or collecting statistical data on their clients. Many assessments and data collection forms use direct westernized language that may imply victim blaming, and/or trigger sensations from traumatic memories. The potentially negative experience may be further compounded by how the social worker asks the questions. Using universal trauma-and-violence precautions means that it may be important to re-word intake forms to lessen triggering language, and that it might be helpful to spread the intake assessment over two to three appointments. In addition, the social worker should focus on how the client was successful with decisions they made and how they can find self-determination.

Western-based intakes and intervention frameworks that focus on deficit and disease-based explanations are ineffective. Instead of asking a client where they have failed in controlling their depression, the trauma-and-violence informed care social worker may instead ask the client about when they have felt joy and happiness. Notice the difference in the questioning. After identifying strengths, the social worker then invites discussion about what supports the client needs or what barriers the client is facing. People seeking supports may begin to feel that the assessment process is meant to find blame and label them. Braiding cultural responsiveness into the assessment process can include holding a focus group with clients (with informed consent) and Knowledge Keepers to discuss the assessment process and intake documents, and to assist social workers to review their assumptions through a critical lens; thus, the social worker may be prepared to inform clients more effectively about the purpose of the support/intervention offered.

Employing Cultural Suitability When Working with Clients

Culturally-suitable, trauma-and-violence informed care includes the following: the social worker's level of confidence in providing such care, use of and competence in culturally-informed treatment programming, support for culturally-responsive healing options, and referrals to suitable community-based resources. To employ culturally-suitable and trauma-and-violence informed care (TVIC), social workers may start by seeking to understand how colonial trauma has, and continues to influence the neurological functioning of both the social worker and the client. As discussed earlier in this chapter, structural racism is embedded in governmental institutions where many social workers work. The practice of neurodecolonization works to correct cognitive biases and current western mindlessness created by colonization (Yellow Bird, 2013). Social workers who are on their own healing journeys are invited to use neurodecolonization and encourage clients to implement the same contemplative-based practice to support positive, healthy neural networks for themselves (Yellow Bird, 2013). One-on-one interactions must take into consideration the importance of creating a safe space, mitigating triggering language, supporting self-determination, focusing on strengths, and practicing neurodecolonization.

Disadvantaged By the System and Also Representing the System

In employing trauma-and-violence informed practices, the social worker becomes the intervention approach. Social workers are invited to explore their own biases and experiences with colonization and, in turn, how their perspective influences their decisions. Seldomly made known are the experiences of the social workers who themselves are members of the BIPOC or 2SLGBTQ+ communities. The intersectionality of being a member of a disadvantaged group and also being a representative of the system creating the disadvantage must be explored. Additionally, clients may hold biases and prejudices against the social worker based on the social worker's gender, sexual orientation, presenting colour, ancestry, or community ties. This chapter cannot address the many perceived and real threats of speaking against the system one is representing as a disadvantaged member. The discussion is bigger than the space allowed, and the authors are not in a position to lead it. However, the conversation must start. Social workers sitting in privileged spaces must take on the role of ally. BIPOC and 2SLGBTQ+ social workers know where to find support from each other, but that is not enough. Together, ally and disadvantaged create the role of disrupter. Ways to become disrupters are to a) Ask questions, b) Find out where you are most valuable in making change, c) Communicate with each other as often as possible, d) Recognize the intersection, and e) Mitigate secondary trauma.

Screening for Trauma

People have an autonomic nervous system that regulates the body's functions. Heart rate, breathing, temperature, and digestion fluctuate throughout the day in response to many situations. Disruptive experiences initiate the fight, flight, or freeze response (autonomic system) to help people to become aware, protect, or defend themselves, and then return to normal. Trauma interrupts one's natural orienting and protecting responses resulting in fixated physiological (Levine, 2010) and psychological states. Peter Levine developed the Somatic Experiencing ® theory, which was discussed earlier in this chapter, to work through the immobility (freeze) phase and complete the impaired survival response (fight or flight):

> *If the immobility phase doesn't complete, then that charge stays trapped, and, from the body's perspective, it is still under threat. The Somatic Experiencing® method works to release this stored energy, and turn off this threat alarm that causes severe dysregulation and dissociation. (Somatic Experiencing® International, 2021, para. 5)*

It is important for social workers to screen for trauma experiences by holding in their awareness theoretical frameworks about the effects of colonization, the establishment of systemic racism, and the physiological and psychological responses to trauma and violence. Through this awareness, they create an environment for the client to share what supports and resources they need without forcing them to relive their trauma story. Social workers can "acknowledge the root causes of trauma without probing" (Government of Canada, 2018, p. 10). To do this they should express concern, listen without judgement, and recognize the client's strengths.

Delivery and Intervention

Being trauma-and-violence informed involves having cultural competence regarding the traditions and practices of any specific culture. When working with rural and remote peoples, an understanding of their cultural practices is essential in promoting and supporting the healing process. Traditional healing practices are localized and culturally specific (Klinic Community Health Centre, 2013). Social workers employing culturally-responsive trauma-and-violence informed care will invite local Knowledge Keepers and clients to inform them and the organization about what should be included in delivering general care and intervening in situations. It is therefore important to be curious about the culture of your client and avoid inaccurate assumptions. Paramount to trauma-and-violence informed care is that the client has a choice over their support and should always be referred to the most appropriate agencies for a full complement of services. An example of this is the work done through the Regina, Saskatchewan based Wellness Wheel. Established in 2016, this agency works to provide enhanced and equitable access to care, by true engagement in the community to inform front-line services (Wellness Wheel, 2016). Local Knowledge Keepers, peer advocates, and users engage in discussion with front-line service workers to braid Indigenous culturally-responsive treatment options into care for people living with HIV/AIDS and other chronic conditions.

Counselling, Consultation, and Programming

Social workers value clients' right to self-determination or control in decisions about their overall well-being (CASW, 2005). Self-determination is the ability to hold control over one's choices or the community in which they interact. It is assumed that trauma-impacted people had control taken from them; therefore, the social worker's role is to provide a trauma-informed process that reintegrates control into the client's decision-making processes and physiological awareness. Clients often feel a lack of voice within systems that perpetuate victim-blaming, or ignore the effects of colonization, and preserve systemic racism. Social workers willing to build a strong understanding of how colonization and intergenerational trauma has impacted Indigenous peoples' well-being, and in turn support the client and community self-determination (Reading & Wien, 2013), will reduce barriers and misunderstanding.

Mezzo and Macro Levels

The social work practice area at the mezzo-level includes working with groups and organizations (schools, businesses, neighbourhoods, hospitals, non-profits, and small-scale communities), in rural and remote areas. Cultural-responsiveness and trauma-and-violence informed concepts braided into social work practice competencies focuses on accessibility, advocacy, and administration. Accessibility, availability, and adaptability of services, directly and indirectly, affect Indigenous service-users' well-being (National Collaborating Centre for Indigenous Health [NCCIH], 2019). Rural and remote service areas experience barriers to care stemming from "colonialism, geography, health systems, health human resources, jurisdictional issues, communications, cultural safety, and traditional medicines" (NCCIH, pp. 1-2). People living outside of urban areas experience inequitable access to care. For example, the *Indian Act* directed Indigenous peoples to live in rural and remote locations thus creating issues with recruiting and retaining service providers. Rural and northern communities find it difficult to fill social work positions and keep workers, long term. As well, jurisdictional issues relating to service coverage prevents clients from accessing available and culturally-suitable services promptly.

Social workers at the macro-level work with large-scale systems (laws, government policies, funds, activist groups, social policy) in rural and remote areas. Advocacy is an expected role of social workers (CASW, 2020). Social workers seek "to improve systems and to address structural or systemic inequalities" and work to implement "Strategies that include members of a community in conversations and actions" (CASW, 2020, p. 4). An example of providing advocacy through a trauma-and-violence informed, culturally-responsive practice framework could be to provide support to 2SLGBTQ+ persons seeking transition or crisis housing in rural or remote locations. It is true that across Canada, self-identified women in general face higher incidents of intimate-partner violence (Public Safety Canada, 2021). Programs usually assume that relationships are heterosexual; and therefore, often exclude or discriminate against lesbian or bi-sexual relationships. Further marginalized individuals are two-spirited people, men, transgendered, queer, or non-binary survivors because they do not fit into the gendered norm of heterosexual women survivors of intimate partner violence. Holding local focus groups with 2SLGBTQ+ community members to determine their unique needs along with culturally suitable responses and treatment approaches can inform social workers about where and how to advocate for their clients in rural and remote locations where services are limited. Solutions to accessing services may include, not having to explain experiences of abuse or sexual orientation, and housing transgendered people in smaller groups to improve feelings of safety and control. A decolonial culturally appropriate approach includes getting to know the 2SLGBTQ+ community to strengthen relationships and trust, especially for client's requiring transitional or crisis housing. Social work as a profession includes working for changes in policies and systems knowing the specific needs of the community that they are representing. They in turn with communities can inform the police, law-makers, and the public on how to reduce harm and mitigate trauma-and-violence experiences.

Conclusion

This chapter offered a discussion and exploration of a braided framework as a foundation to begin developing the social worker's competencies for work with rural and remotely located Indigenous clients by increasing safe and suitable accessibility of services and ensuring appropriate and timely referrals. Working with trauma impacted clients means acknowledging that they may have experienced, or continue to experience, violence. The goal for social work practice in these communities with these populations is to mitigate triggering experiences and reduce harming incidents. This chapter invited the social worker to identify power imbalances in rural, remote, and northern practice. The sections wove the principles of trauma-and-violence informed care and the Indigenous Cultural-Responsiveness Framework along with practice competencies. With this information, social workers should be able to begin aligning social work competencies with universal trauma precautions. Braiding in culturally-suitable perspectives and healing approaches strengthens client care efficacy. Creating relationships and reducing triggering language creates space for honest well-being related sharing. *Braiding in* is about exploring respectful approaches that support healing. Moreover, organizations can work to provide ample time and resources to create space for meaningful engagement.

Wanda Seidlikoski Yurach: My Indigenous colleagues and friends have taught me to position myself in the context of my relations as well as the area which I was brought up as a decolonizing relational method of introduction. I am a 58-year-old woman of Eastern European decent. I have been married for 38 years, have four children and two grandchildren. I grew up on a farm in southern Saskatchewan, lived in Prince Albert for 28 years, and since September 2018 now call Saskatoon my home. I have filled many roles in my career including being employed with the Saskatchewan Government (Corrections and Social Services) and the Saskatchewan Health Authority (Mental Health). In addition, I maintain a private practice in Saskatoon and work as a Sessional Lecturer at the University of Regina (Faculty of Social Work). I acknowledge my family and relationships are key to who I am. I also acknowledge that the most fulfilling aspect of my career has been working for the last 17 years as a mental health therapist/coordinator in northern Indigenous communities in Saskatchewan.

Carrie LaVallie: I am a third-generation-born white Settler with Scandinavian and German ancestral ties. I have worked with First Nations University of Canada for twenty years and hold a small private practice working mostly with Indigenous peoples. My white skin affords me a position of privilege that is unwarranted but there and should be acknowledged. It is through this privilege that I, at times, believe I have a right to say things in a forthright manner. My intention in co-writing this chapter is not to offend anyone but to assist in making sure all clients are treated with respect by upcoming and current social workers. As a therapist, I pay close attention to people's behaviours and analyze needs. This lens prompts me to offer guidance about what may work for some people and should not be seen as absolutes. This chapter is an invitation to ensure that we are all seeing the client as a person and not as a clinical number.

[1] Concept used to describe a collective way of beliefs and values imposed upon Indigenous peoples by European-centric settlers, who enforced a Christian and positivistic viewpoint.

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Child Protection in a Rural Setting

13

Cathy Rocke

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This chapter will review the unique aspects of providing mandated child protection services in a Canadian rural setting. First, the development and current state of child welfare in Canada will be presented with specific reference to child welfare services in rural Canada. Secondly, a review of rural social work practice models and the characteristics of effective rural social workers will be explored. Finally, the policy, practice and ethical considerations of child protection within a Canadian rural setting will be presented, drawing on the author's experiences working in a rural community.

Learning Objectives

By the end of this chapter you will have had the opportunity to:

- Describe the theories of rural social work practice.
- Describe the history of child welfare services in Canada.
- Explain the principles of effective child protection practice and how these principles have unique aspects in a rural setting.
- Discuss how your own values may help or hinder your ability as a child protection worker in a rural setting.

Child Welfare in Canada

Intervention by the state into the family is relatively recent in Western countries. During Roman times, laws were based on the concept of *patria potestas*, which viewed children as the property of their fathers allowing them complete control over their children's lives. This control included the right to sell his children into slavery or even put them to death. With the spread of Christianity, the powers of the father became more circumscribed but still allowed fathers the right of "reasonable chastisement" of their children (Bala, 2004, p. 2). With the advent of the Industrial Revolution in the mid-19th century, the condition of children began to gain the attention of social reformers that resulted in the beginning of the child welfare system.

The development of the current child welfare system originated in urban centers. Social reformers including J.J. Keslo—founder of the first Children's Aid Society in Toronto—were part of the Child Saving and Child Rescue movements (MacLaurin & McCormak, 2007). The increasing numbers of neglected and abandoned children in urban settings were the focus of these movements. Members were motivated by their Christian beliefs to save these neglected and abandoned children from their current circumstances to be raised in good Christian homes (Cameron et al., 2007). Ontario became the first province in Canada in 1893 to enact legislation allowing the state to intervene in families and remove children from their caregivers, if the children were deemed to be neglected or abandoned (Bala, 2004). In Manitoba and Saskatchewan, the first child welfare legislation was enacted 1898 and 1909 respectively (Dornstauer & Macknack, 2009; Hurl, 1984).

Despite the enactment of child welfare legislation in most provinces at this time, delivery was urban-focused, and delivery of services to rural areas was left to either the family and/or churches in the area to address (Dornstauder & Macknack, 2009). Child neglect, youth delinquency, unwed mothers and the most severe cases of physical abuse remained the focus of any child welfare interventions for the next 50 years (Bala, 2004; Oliver, 2017).

With the medical discovery of the "battered child syndrome" in the 1960s by radiologist Dr. Kempe, public awareness of child physical abuse increased dramatically (Cameron et al., 2007). In the 1970s and 1980s child sexual abuse came to public attention and, along with the adoption of mandatory reporting laws, dramatically increased the numbers of families that were reported to child welfare authorities (Bala, 2004). Over this time period, the stigma against unwed mothers receded and child welfare authorities' involvement was restricted to underage mothers with limited familial support. The responsibility for young offenders also shifted to the youth criminal justice system after several legislative changes (Bala, 2004). The focus on child abuse in child welfare agencies resulted in child protection workers gaining skills in forensic techniques similar to those used by law enforcement. Coupled with the use of the adversarial court system to determine the fate of abused and neglected children, this shift undermined the ability for many social workers to develop helping relationships with their clients (Oliver, 2017).

The location of most child welfare agencies has been in large urban settings since their inception. Historically, child protection services in rural areas were often left to volunteer community groups or churches. Rural children that came to the attention of authorities would be placed in urban institutions or foster homes upon removal from their familial homes (Dornstauder & Macknack, 2009). The history of child welfare services in Indigenous communities is distinct from the above history, and is outside the scope of this chapter. The genocidal Residential School system which systematically removed Indigenous children from their families and communities (Hamilton & Sinclair, 1991) and the 60s Scoop that initiated the forced removal and adoption of Indigenous children into non-Indigenous homes across North America and Europe have resulted in the overrepresentation of Indigenous children in state care today (Mandell et al., 2007).

The current child welfare system is predicated on a threshold model – that is, families have to meet a specific threshold to come to the attention of child protection workers. As a result, most child welfare systems provide reactionary services rather than preventative supports to help families struggling with parenting. Over the years, there have been several critiques of the threshold model, especially since the adoption of mandatory reporting requirements in most jurisdictions (Lonne et al., 2016). Many of the families that come to the attention of the system are marginalized within society (e.g., Indigenous, people of colour and families living in poverty) and would benefit from tangible resources. The current structure and funding models of child welfare systems do not adequately support the needs of families living in poverty. The focus on child protection by the system results in a focus on individual pathology instead of the systemic issues that impact families. Often the primary response to confirmed cases of child abuse and neglect is to remove the children from the home, which has resulted in dramatic overrepresentation of children from marginalized communities in care (Cameron et al., 2007).

Unique Aspects of Rural Social Work Practice

Rural communities have been defined in multiple ways, but “ultimately, rural communities are communities of people” that can “be locational, geographical, or associational” (Daley, 2021, p. 8). World views and values often set rural communities apart from urban settings. Riebschleger and Pierce (2018) suggest that rural people belong to a diverse group who can experience social and historical stigma, and they emphasize the importance of personal relationships in rural communities. Daley (2021) indicates that this element is often demonstrated in the close-knit communities that value family connections which often become individuals’ primary support. Informal helping networks are also common, such as reliance on neighbors or religious institutions (Riebschleger, 2007; Riebschleger & Pierce, 2018). Churches are gathering places for families and in some rural communities are the only viable option to obtain assistance (Lewis et al., 2013). In a study conducted by Zellmer and Anderson-Meger (2011), rural residents from two Midwestern states reported that they were less likely to trust a professional social worker over their church, which impacted their use of services and relationships with social workers.

Ginsberg (2011) identifies higher levels of depression, substance abuse, domestic violence, and child abuse in rural settings. In a Canadian context, rural rates of police-reported violence against children and youth was nearly twice as high compared to urban settings. Women residing in rural areas experienced higher rates (789/100,000) of interpersonal violence than urban women (447/100,000) in 2018, with rural women in Saskatchewan and Manitoba with the highest rates in comparison with other provinces (Burczycka, 2018). A survey of rural physicians found that alcohol abuse was a major issue facing patients in rural British Columbia and that 76.4% of the respondents reported difficulty referring these patients for treatment, due to limited services (Slaunwhite & Mcdonald, 2015).

In a study of rural homelessness in Alberta, Schiff and Turner (2016) found that youth, victims of domestic violence, newcomers and Indigenous peoples were noted as sub-populations of rural homelessness. From an international perspective, Pugh and Cheers (2010) discuss the impact of changing local, regional and international economies on rural communities. The authors suggest that it is important for social workers to understand the consequences of higher unemployment rates and depopulation in rural areas and how these factors shape the lives of their clients. Riebschelger and Pierce (2018) add that child welfare workers should have an understanding of the historical context of rural communities they reside in, many of which were founded on agriculture and extraction economies. The decline of these industries can affect the overall sense of community.

There has been debate over the years about what type of social work practice works best within rural settings. Initially, it was argued that community development approaches were most appropriate based on the lack of resources available in rural areas. Currently, it is generally agreed that a generalist approach works best, as it allows social workers to use “multiple methods to address individual, family, group, organizational, and community problems” (Daley, 2021, p. 213). Generalist social workers are

defined as practitioners "whose knowledge and skills encompass a broad spectrum and who assesses problems and their solutions comprehensively" (Barker, 2014, p. 174). Rural communities often have limited specialized resources compared to more urban settings; rural social workers need to adopt a generalist practice approach that includes providing a variety of supports, whether it be basic life skills, counselling for mental health concerns, or advocacy for specialized housing (Schmidt, 2021). Furthermore, Daley and Avant (2014) suggest that although a generalist approach has been deemed best suited for rural practice settings, there is still a need for social workers to hold specialized and advanced skills in specific areas.

There is a need for a mixed model of strength based as well as a collaborative approach that aim to empower individuals and communities in identifying their unique needs for both formal and informal resources. As Riebschelger and Pierce (2018) suggests, rural social workers report that working in these areas requires a great deal of independence, creative thinking in terms of accessing services, and interdependence among service providers. The literature suggests that due to the complexities of issues faced by rural and northern communities, there are higher expectations for social workers not only to fill multiple roles, but also to utilize various practice models to ensure they are meeting the needs of clients and communities.

Daley (2021) expands on the generalist approach to detail the theoretical perspectives that inform his model of rural social work. His model integrates a systems, problem-solving and person-in-environment perspective into the generalist practice. He advocates for an expanded strengths perspective that includes both individual strengths and community assets, and which encourages rural social workers to use the concepts of *Geimeinschaft* and *Gesellschaft* from social exchange theory in their assessments (Daley, 2021).

The generalist approach is rooted in systems theory that informs social work assessments by understanding issues on individual, familial, group, organizational and community levels. The problem-solving method provides a guideline to engage, assess and work towards solutions for issues that are presented to social workers by clients, families and communities. The person-in-environment perspective closely aligns with ecological theory by highlighting how the individual and their environment affect each other in both positive and negative ways, and can reinforce behaviors (Barker, 2014; Daley, 2021).

A strengths perspective ensures that social workers review the support systems, resources and capacities at individual, familial and community levels instead of assuming a deficit approach to problems that are presented (Saleebey, 2012). Daley (2021) argues that a strengths perspective is particularly important to counter the stigma against rural peoples present within society that has been perpetrated by popular media. Finally, drawing on social exchange theory, Daley (2021) encourages rural social workers to utilize the concept of *Gemeinschaft* to understand areas characterized as "local, closely integrated community" whose "members share strong values and beliefs and maintain personal and direct social bonds (Barker, 2014, p. 172). In contrast, urban communities are described by the concept of *Gesellschaft*, a "complex, impersonal type of society" whose "members possess few shared values and have social bonds that are impersonal, narrow, and strictly functional" (Barker, 2014, p. 177). Both concepts are classic descriptions of rural and urban communities, and most areas fall along a continuum. Rural communities can vary depending on location and geography, and with the arrival of the internet in some communities the classic characterization of rural communities has dramatically changed.

Rural social workers need the ability to be creative, be community based, engage successfully in interdisciplinary work, be open to working with natural helpers in the community, and demonstrate ethical behavior in their private lives. A commitment to continuous learning by rural social workers is vital to the wellbeing of their clients. This commitment includes learning about the social environment in which they are situated, and strengthening their understanding of general values and perspectives. Daley (2021) argues that "the effective rural social worker has to mine the existing books and articles for relevant content on rurality" (p. 37). In my own practical experience, I spent time learning about the history of the Mennonite population that had returned to Canada from colonies in Mexico and Paraguay and whose children were coming to the attention of child protection services. I also endeavored to understand values rooted in their Christian faith that influenced how they raised their children and interacted with the outside world (Harder, 2021). It is important that rural child protection workers understand that parents from conservative religious communities will often seek parenting advice solely from their religious leaders (Loue, 2017).

Understanding the values of any rural community is important for rural child protection workers to be effective (Harder, 2021). Harder (2021) advocates that protection workers should demonstrate "a stance of curiosity about their faith, values and ways of life" (p. 73) that can help to develop trust and a positive working relationship. Schmidt (2021) advocates that social workers complete a community profile that include information on the "history of the community, information on geography and climate, local government structure, important cultural and social events…economic indicators…employment rates, housing stock…and the

degree of economic equality and inequality" (pp. 216-217). Without this information it will be more difficult for social workers that are new to the area to develop rapport and effective working relationships with community members.

The practice of cultural humility by rural social workers is critical as rural communities vary and understanding the context of each community helps clarify the socialization of those being served (Daley, 2021; Norris, 2018). In contrast to cultural competence which positions the social worker as the expert in specific cultures, Ortega and Faller (2011) maintain that cultural humility shifts the workers' stance to one of continually learning about the culture from the clients' perspective. The specific skills needed to practice cultural humility include active listening, reflecting, reserving judgment, and entering the client's world. The foundation of these skills is the willingness of the social worker to "develop self-awareness and a respectful attitude toward diverse and multiple points of view" (Ortega & Faller, 2011, p. 44). This perspective fits well with the relational approach to child protection in a rural setting that will be expanded upon further in the next section.

Examples

Working with a Suicidal Youth from a Closed Religious Community

- Sarah (fictional name) was referred by a high school guidance counsellor after she expressed suicidal intentions, refused to go home, and requested to be placed in foster care. Sarah was a member of a closed religious community that had rigid gender expectations. Her suicidality risk was assessed and determined to be non-lethal; however, Sarah was distressed about her home environment which she viewed as very restrictive. She expressed the desire to dress like her school peers but had been warned by her family and church community that these behaviors were forbidden. Sarah was told that her desires were temptations by the devil and could result in her soul being in danger. She had been threatened with expulsion from the church if she continued in her resistance to the church rules.
- Sarah was placed in a foster home to further assess the situation. It was determined that her family and community had been pressuring her to quit school and fulfill her role as wife and mother. Consultation with colleagues familiar with this particular Christian church indicated that education is equated with the first deadly sin of pride and that members were encouraged to obtain only a level of education that was needed in their future role in life. Women were not encouraged to seek education beyond age 11, as their primary role in life would be as a wife and mother. Male members of the community might continue to age 12 in order to gain a level of education to help with their interactions with the outside world (e.g. basic literacy and numeracy skills) (Good Gingrich, 2016).
- I began counselling Sarah about other options she might want to explore, including furthering her education. Later, while consulting with my fellow colleagues I was told that I was using the "f-word" with this youth – feminism! I made attempts to meet with the parents, but in the end was only able to speak with the mother over the phone as she refused a face-to-face meeting. During our telephone conversations, she very clearly expressed that I was "stealing" her daughter and remained deeply concerned for the soul of her child. After a short stay in care, Sarah eventually decided to return to her family, and I was later told that she had quit school and married a young man from her church community shortly afterwards.
- After reflection, I realized that I had initially been in culture shock as the ideas exposed by this church community were difficult for me to accept. The devaluing of education was particularly offensive as I was raised in a family where education was highly valued – especially for women. I also found the acceptance of patriarchal beliefs by this church community an affront to my feminist social work practice. It was difficult to practice cultural humility in this situation!

Examples

Investigating Child Physical Abuse

- The agency received a physical abuse allegation of a parent against their young child. During the assessment exploring the natural helping networks of the family, I arranged to meet with the family pastor. His initial comment to me was very clear that the agency that I represented lacked credibility within their community, as it was "not of God." He stated that his church members believed in the literal interpretation of the Bible and adhered to the interpretation of the scripture that warned community members that to "spare the rod [is to] spoil the child" in their parenting strategies. I was taken aback by his argument and felt I could not respond adequately due to my own lack of knowledge of biblical text. I was taken aback by his argument and felt I could not respond adequately due to my own lack of knowledge of biblical text and having grown up in a non-Christian home.

- Afterwards I sought guidance from a pastor that worked with the agency to help me understand this particular interpretation of the Bible. First, the pastor explained that the expression “spare the rod and spoil the child” was not actually a biblical quotation but is found in subsequent theological interpretation of Proverbs 13:24.[1] Depending on the interpretation, the passage can be taken literally or understood as a metaphor for how to discipline children. He explained that his own interpretation of the scripture was that the “rod” referred to a shepherd’s staff which is used by shepherds to guide their animals in the right direction. Shepherds do not use their “rod” to hit the animals as this would damage their livestock! With this interpretation, the pastor suggested that parents should be counselled to use communication rather than physical punishment in guiding their children.
- The parental use of physical discipline has been hotly debated in Canada (Durrant, 2007). Several researchers have advocated for the complete abolition of physical punishment of children (Durrant et al., 2017; Straus, 2001). Most child welfare legislation across the country identifies physical abuse as a reason to intervene within a family and potentially remove the children from the home. However, the definitions of physical abuse have been vague and open to interpretation by individual workers. To complicate the issue, until 2004, Section 43 of the Criminal Code of Canada (1985, s 43) allowed parents to use “reasonable force” in the correction of their children, and had been used as a defense by parents who had been charged with physically assaulting their children. In a landmark case heard by the Supreme Court of Canada, the court identified seven criteria to differentiate between reasonable force and physical abuse in an attempt to “better protect children while still protecting the adults who use corrective force against them” (Durrant et al., 2017). Today, the issue of physical discipline remains controversial and results in challenges for child protection workers responding to allegations of physical abuse.

[1] Proverbs 13:24 He that spareth his rod hateth his son: but he that loveth him chasteneth him betimes. (King James Bible) or He who withholds his rod hates his son, But he who loves him disciplines him diligently. (New American Standard Bible)

Policy, Practice and Ethical Aspects of Child Welfare in a Rural Setting

Policy

The field of child welfare has been described as an “ideological battleground” (Cameron et al., 2007, p. 3) as the policies and practices of the system reflect the current beliefs about children, families and the right of the state to intervene in family affairs. Canadian legislation, policy and practice reflect these shifting beliefs over time. Since the inception of child protection systems, the areas of policy and practice have seen pendulum swings in Western countries between child protection and family support (Cameron et al., 2007). Increased public awareness through sensational media reports (Lonne et al., 2016) and government inquiries highlight the failures of the system, with front line workers accused of either not intervening soon enough to save a child or of intervening in a manner criticized as state overreach (Cameron et al., 2007). As a result, child protection is one of the most difficult and stressful jobs in social work practice (Lonne et al., 2016).

Within rural settings, the family support services that might be more accessible in an urban context are often not available (Belanger et al., 2008). Furthermore, most child welfare policies are developed with an urban lens and reflect little understanding of the rural communities (Delaney & Brownlee, 2009). For example, child welfare policy has encouraged protection workers to access day care services for families at risk, when these services or access to transportation may be unavailable in rural settings.

Rural Child Protection Practice Models

Daley (2021) presents a good framework for rural social work practice that integrates a strengths perspective; however, child protection workers need to understand the complexity of child protection work and acknowledge the mandate they are charged with, by never underestimating the risk inherent in cases of child abuse and neglect. Turner (2017) argues that “to do child protection work well we need a mind like a steel trap infused with the compassion of the Buddha” (as cited in Oliver, 2017, p. viii). Oliver (2017) similarly presents a strengths-based approach integrated with solution-focused models to highlight the need for positive relationships with families and children involved in the system, while still ensuring assessment of all family members’ safety. Assessment frameworks such as the *Signs of Safety*® developed by Turnell and Edwards (1999) emphasize the need for relationship-based approaches within child protection practice (Oliver, 2017).

The relational approach to child protection does not seek to “individualise problems and blame parents for not being able to look after their children,” but rather looks for solutions that harness the strengths within the family and community, and provides

additional support to help families function well enough to care for their children (Lonne et al., 2016, p. 133). The relational approach combines the "*respect for persons* and *social justice*" through the lens of social relations within the family and community (Lonne et al., 2016, p. 133). It is important for child protection workers to acknowledge the power they hold within their positions. It is very easy for child protection workers to become punitive in their interactions with a family, especially when workers lack experience or adequate supervision, in severe cases of child abuse, or when workers are experiencing stress (LeBlanc et al., 2012; Lonne et al., 2016).

de Boer and Coady (2007) advocate that good child protection workers demonstrate a relational approach to families by combining the "soft, mindful and judicious use of power" with a "humanistic attitude and style that stretches traditional professional ways-of-being" (p. 35). Some of the practice strategies suggested include: an understanding of power and how that impacts families; responding to hostility from parents with compassion and understanding; providing accurate and honest information about the reasons for the involvement of the worker; avoiding prejudgement of referral information by deeply listening to the perspectives of the family; looking for strengths within the family and community; demonstrating a genuine and down-to-earth attitude; developing relationships with the family through small talk; getting to know the whole family utilizing a person-in-environment context; and finally, being hopeful about the family's ability to cope and to meet mutually-set goals (de Boar & Coady, 2007). Child protection workers need to develop a level of comfort and skill in dealing with tension and potential conflict inherent in child abuse investigations. Karp (1984) outlines the steps in dealing with resistance, which include acknowledging, surfacing and honoring that resistance to deepen the relationship between the worker and parents.

Oliver (2017) developed a model for child protection practice which she describes as "firm, fair and friendly" after interviewing several Canadian child protection workers. She found that many of the workers adapted the strengths perspective by acknowledging the state power inherent in child protection work and using this power constructively to help parents provide better care for their children. Oliver (2017) argues that the field of social work has historically ignored the concept of power within worker-client relations or sought to equalize this power dynamic. The "firm, fair and friendly" practice model seeks to balance collaborative approaches with the use of power constructively. The mandated power that child protection workers hold is acknowledged and interrogated to be used judiciously to ensure child safety. To follow this practice model, child protection workers need to complete their assessments impartially and listen to all the perspectives, so they can fully understand the family dynamics and be continually open to new information. During this process, workers constantly assess their interactions with the family and adjust their use of collaboration and authority techniques accordingly. Finally, the foundation of the model is transparency with the family. Workers need to be honest about the reasons they are involved with the family, and the responsibility and response of the worker and agency to child safety concerns.

The current child welfare system continues to adopt an individual focus in child protection services. Abusive or neglectful parents are assessed without taking into consideration their social location or socioeconomic status. Lonne et al. (2016) argues that the child welfare system needs to move away from this focus on parental blame and the narrow definitions of the best interests of the child towards a relational approach with parents and a focus on family and community networks that will engage meaningfully in problem-solving. The integration of anti-oppressive and feminist approaches within child protection practice are important for rural social workers to help deconstruct organizational and societal contexts such as the overrepresentation of marginalized populations within the child welfare system and focus on how patriarchy plays out in family dynamics (Lonne et al., 2016).

Examples

Firm, Fair and Friendly Child Welfare Practice

- Drawing on my own experience as a child protection worker, there was little guidance on how to engage parents when completing child abuse investigations. Agency training in this area focused on forensic interviewing techniques borrowed from law enforcement to ensure that disclosures obtained would be admissible in any potential criminal court proceedings. Training did not include learning how to handle hostility from parents, or how to use conflict resolution techniques. As result, I remember many of my own or colleagues' interactions with parents as frustrating, since parents predictably denied culpability and resisted any engagement with the agency.
- Discussion about the level of power held by child protection workers also did not happen frequently within the workplace. I was advised early in my career that in my role as a child protection worker I held more power than the police to intervene in families. Police usually have to obtain a warrant from a judge to enter private property, whereas child protection workers had the authority to enter a home without a warrant, and to remove the children if they reasonably believed the children might be at

risk of abuse or neglect. Thankfully, also early in my career, a very wise supervisor likened the power inherent in child protection work as one side of a coin. The other side of the coin included the responsibility that I bore to ensure that I knew what I was doing if I ever had to use this power to remove children from their family home.

- My own practice did include some aspects of the "firm, fair and friendly" model (Oliver, 2017) as I worked to be completely honest with parents about the concern that had come to the attention of the agency, my role, and what needed to be done to allow their children to return home. I also used humour to ease the resistance I encountered by stating one of my goals was to "work myself out of their lives." With this comment I hoped that parents would work with me, rather than against me, to address the issues.
- Finally, my own social work practice included trying to suspend any judgements about a family from the initial referral information by listening to as many family members as feasibly possible to develop my own assessment. One of my first experiences when I began my child protection career was to be handed a very thick file from a seasoned child protection worker who told me "forget all that stuff you learned in school – here is the real world and good luck, this family is F$%^#@ and has been involved in child welfare for several generations!" It was a depressing introduction to the field, but I became more determined that day never to prejudge a family until I had completed my own assessment, and not to lose my belief in people's ability to change. When I first went out to meet the family, I asked that they tell me their story from their own perspective, and I received some very valuable information that was not in the file. I was not naïve that child protection concerns continued in this family situation, but I now had a much deeper understanding of the family dynamics by engaging with the family and allowing them to share their side of the story.

Rural Child Protection Worker Characteristics

Many of the characteristics of effective rural social workers are the same as those needed for successful rural child protection workers. As mentioned earlier, rural social workers need to be creative, community-based, able to work with other professional disciplines, natural helpers, practice cultural humility, and demonstrate ethical behavior in both their practices and their private lives (Daley, 2021). Riebschleger et al. (2015) identify that rural child protection workers need to have knowledge of rural poverty, lack of formal resources, and historical trauma affecting many rural populations. Oliver (2017) maintains that successful child protection workers should demonstrate humility and comfort with the power inherent in their role. Child protection workers who operate from the "firm, fair and friendly" model demonstrate humility by "constantly learning from their clients, their colleagues, their families, and their mistakes" (Oliver, 2017, p. 177). The power within a mandated role includes both the acceptance that child protection is important and necessary work, and conviction that power and authority can be used constructively to help make families safer for children (Tuck, 2013).

Examples

Working Across Disciplines

- Working rurally requires that child protection workers work closely with collaterals. In my own practice, I worked diligently to develop a good working relationship with members of the local RCMP detachment so that any child abuse investigations could be undertaken in a way that reduces the number of times that victims had to tell their stories. Most jurisdictions mandate interdisciplinary teams for child abuse investigations (Jacobson, 2002); these teams include representatives from child protection and law enforcement, as well as medical personnel. These jurisdictions' policies allowed interdisciplinary teams the ability to share information and thereby facilitate a coordinated response to child abuse reports.
- One of the barriers to maintaining these working relationships with RCMP members, in my own practice, was the rotational schedule of the RCMP. In the context in which I was working, the RCMP officers rotated out of the community every two years. I often felt that I had just developed a good working relationship with specific officers only to have them transfer out and then have to repeat the whole process again with new members.
- My collaboration with local physicians was often more difficult. Several local physicians were resentful of the mandated reporting requirements to local child protection agencies, as they perceived child protection workers as "baby snatchers" that only worked to break up families. This attitude was demonstrated in a call I once received from a local physician who began the conversation with the statement, "I know that your only response will be to remove the children and break up the family once you are made aware of the situation I have to tell you about." I spent some time before receiving the referral explaining that the agency was mandated to make sure that children were safe from any further abuse, but that we would look at a number of alternatives that could ensure that safety. The referral included the alleged sexual abuse of a young child by her father. In this

situation, the family agreed to have the father leave the home until the situation could be assessed and to ensure the safety of the child. During the father's absence from the home, I worked closely with the mother and eventually developed a safety plan that allowed the child to stay in the home. My relationship with the local physician improved after this case, as I had built a mutual understanding that I would work to keep families together as long as the safety concerns could be addressed.

- It is also important to ensure that local physicians have the capacity to assess child abuse allegations. In one particular case, the agency had received a report of a young female child having been sexually abused. Although the agency was within driving distance of an urban hospital that had a specialized child abuse unit, the child was initially assessed by a local physician who anesthetized the child during the examination. Due to the lack of muscle tone in the genital area, the physician declared that the child had been serially sexually abused, and the child was removed from the home. Further assessment did not result in any disclosure from the child or any corroborating evidence until a further examination was scheduled at the specialized child abuse unit. The second evaluation determined that there was no sign of sexual abuse, and that it was the anesthesia that had caused the lack of muscle tone; anesthesia is never used in the medical examination of child sexual abuse victims. Over the years there have been a number of controversies in the diagnosis of child abuse, when child welfare systems uncritically accept the medical diagnosis of physicians (Gabaeff, 2015; Miller-Perrin & Perrin, 2013). Workers need to develop a good understanding of group dynamics of interdisciplinary teams to ensure that child abuse investigations do not result in harm to families (Cowley et al., 2018).

Ethical Issues in Rural Child Protection Practice

Rural child protection practice involves unique ethical issues that social workers need to be aware of, and they should have the tools and skills to address ethical issues when they arise. Barsky (2019) argues that within child welfare practice the "value conflicts and ethical issues are pervasive" (p. 383). Daley (2021) highlights the most common ethical dilemmas to face rural social workers are dual relationships, working in a fishbowl, and confidentiality. Lonne et al. (2016) maintains that ethical dilemmas in child protection are linked to "client vulnerability, unequal power relationships and the centrality of relationship in effective ethical practice" (p. 4) while Barsky (2019) identifies ethical dilemmas that involve value conflicts rooted in religious beliefs as particularly challenging.

The Canadian Association of Social Workers *Code of Ethics* (CASW, 2024) advises social workers to avoid dual relationships, but does not ban these relationships altogether, since dual relationships are often unavoidable in rural communities (Daley, 2021). For social workers in small communities, it is difficult to avoid contact with clients in local grocery stores or at recreational activities (e.g. sports leagues) (Humble et al., 2013). Piché et al. (2015) highlight that some social workers responded to these challenges by limiting their social life within the community; however, this avoidance can lead to social isolation. Daley (2021) advocates that managing dual relationships includes conversations with clients to strategize how to address contact in the community to protect the confidentiality of the clients. For ethical breaches in dual relationships it is important that agencies develop clear guidelines and policies on dealing with these ethical breaches.

Confidentiality in social work practice is a complex area and requires that rural social workers consult regularly with colleagues, supervisors, and their provincial regulatory bodies when ethical dilemmas arise. One of the major challenges to confidentiality is the receipt of third-party information when working in rural communities (Halverson et al., 2009). The community size and personal connections among individuals results in most people having information about each other (Piché et al., 2015). Agency staff within child protection agencies, who have resided in rural communities for years, often have relevant information about community members that is typically not available to urban child protection workers. In my own experience, these agency staff can provide valuable informatio[1]n on new protection intakes which allow an initial assessment on the risk to the child, family history, natural helpers, and any risk of violence towards the worker. Child protection assessments rely on accurate information so the worker can make informed decisions and plan successful interventions. On the other side, although I may have been made aware of some information from agency staff members, I was always very cautious to complete my child protection assessment from my direct interactions with the family and significant others. I also would ask families to give me their perspectives on any "community stories" that had been shared with me.

Consultations with colleagues are very helpful in working through ethical dilemmas. The structure of the rural child protection unit in which I was employed allowed for discussion about ethical dilemmas within the weekly team meetings where critical decisions (e.g. removal or return of a child to their family) were made. The role of the supervisor was critical in creating the environment for healthy dialogue about how some of our own values could be affecting our decision making. I recall one contentious family

situation that involved emotional abuse and neglect. The father was observed to be verbally abusive towards his young child, who was exhibiting concerning behaviors (e.g. being silent when playing with his toys so as not to elicit an angry response from his father); the mother was assessed as often neglectful of the basic needs of the child. One member of the team strongly advocated for the child's removal, as she argued that the threshold had been met for child abuse; however, other team members felt that removal of the child without any physical injuries would be difficult to prove in court, and that premature removal of the child could be more detrimental to the child's wellbeing. In one team meeting, this worker strongly advocated for apprehension of the child to "teach the father a lesson," but was quickly challenged. Further discussion by the team helped this worker acknowledge how her anger and frustration with the parents' behaviour was impacting her assessment of the family situation. Decisions about child abuse and neglect are difficult due to imprecise laws (see case scenario on *investigating child physical abuse*), recognition that child abuse and neglect are socially constructed concepts that are influenced by personal and societal attitudes, and challenges of accurately predicting child protection risk especially in cases of less extreme abuse and neglect concerns (Barsky, 2019).

Ethical decision making includes social workers that practice reflective and reflexive practice as "child abuse and neglect are socially constructed phenomena, and prone to blame, prejudice, discrimination and othering" (Lonne et al., 2016). Reflective practice includes the ability to critically reflect on social work knowledge, values and policy alternatives to ensure that the actions taken in child welfare practice are effective. Rural child protection workers need to continually review their positionality and how their "ethnicity, class, gender, sexuality, ability, religion and other factors create our identity and biases" (Schmidt, 2021, p. 212). Reflexivity widens the lens to help social workers deconstruct current child protection practice to the prevailing societal ideologies (Payne, 2009). Within my own practice, I needed to examine my own values about child abuse and neglect and reflect deeply when I found myself becoming angry about the abuse children were suffering and slipping into punitive responses towards parents. Child welfare organizations need to encourage open dialogue about differing values about parenting and child abuse and how these values can impact individual social workers' practice.

Examples

Working in the Fish Bowl

- An agency worker began an intimate relationship with a married community member who provided volunteer services to the agency. As a result of the relationship, the community member's marriage broke down. News of the marital breakup quickly spread through the local grapevine, and the credibility and reputation of the agency was deeply impacted. Prior to this event, the agency had engaged in a public awareness campaign to highlight the support services it offered to help families. The impact of the behaviour of the agency worker damaged the reputation of the agency and was very difficult for those agency staff who lived in the community. The agency staff who lived in the community cited several incidents in which they were confronted in public places about the behavior of the agency worker and how this damaged their perception of the support services the agency was offering. Rural social workers need to understand their personal behaviour is constantly under scrutiny within small communities (Daley, 2021) and that any mistakes can be very difficult to repair (Schmidt, 2021).

Safety for Child Protection Workers in Rural Settings

One prominent issue for workers involved in child protection is personal safety. Several cases in which I was involved included parents (especially fathers) with a history of violence, and who were often angry about my role in agency intervention. In rural areas there is also easy access to firearms, as guns are used for hunting and safety issues related to lack of easily accessible police services and potentially-dangerous wildlife. In one case, extreme domestic violence towards the mother also endangered the children in the home. The father had threatened both me and the police if the children were removed from his care. When the children were apprehended, my male team colleagues ensured my safety by driving behind me on the way home for a few weeks. Eventually, when the child was returned to the mother's care the father was allowed visitation rights and a male worker was assigned to work with the father.

Historically, child welfare agencies have not had policies to ensure the safety of workers. Increasingly, agency workers and their unions have advocated for mandatory buddy systems when dealing with clients who have a history of violence; also recommended are official policies to guide both workers and their supervisors when clients have demonstrated or threatened physical violence. Child protection workers should become trained in safety precautions and de-escalation techniques (Hawranick et al., 2009). Under most child welfare legislation in Canada, workers can also request the assistance of law enforcement for child apprehensions.

Another way to ensure my safety as a protection worker was for my supervisor not to assign me any cases for the small town in which I lived that was within the catchment area of the agency. This practice did not always provide complete anonymity, as families involved with the agency often travelled between different towns for recreational purposes (e.g. hockey leagues) and there was always a chance that I would run into clients in my off hours. Unfortunately, for many workers in more isolated communities this practice is not possible (Hawranick et al., 2009).

Conclusion

It is apparent that "rurality affects practice" (Daley, 2021, p. 212) and that there are distinct practice realities for rural child protection workers requiring specific skills. Ginsberg maintains that rural social work is "simply good social work that reflects and considers the environment in which practice takes place" (as cited in Daley, 2021, p. 4). Providing child protection in a rural setting compounds the challenges of the work; however, when workers are informed by relational approaches that integrate strengths-based solutions, problem solving models, and critical perspectives it is possible for child protection workers to be effective. As described by Turnell (2010), "the best child protection practice is always both forensic and collaborative and demands that professionals are sensitized to and draw upon every scintilla of strength, hope and human capacity they can find within the ugly circumstances where children are abused" (p. 21). The work of child protection is not for the faint of heart, but when done well, and when engagement and supports are offered so that families and children can thrive, it can be a rewarding social work career.

Dr. Cathy Rocke is of multi-ancestry (Icelandic, Chinese and Metis), who spent her formative years in Nunavut. When she is not working, Cathy reenergizes with her beautiful grandchildren.

Activities and Assignments

- Cultural Humility: Have there been times when you felt uncomfortable in a setting outside your own culture?
  - What specifically made you uncomfortable?
  - Reflecting on your own cultural lens, how could you have approached the situation with Sarah with cultural humility?
- Values about Parenting: Identify your family values with respect to spanking. Review the criteria outlined in the Criminal Code of Canada on reasonable force that can be used to correct children.
  - What was the perception of spanking within your family? Do you still adhere to these values about spanking?
  - What would be your response to parents who feel they have the right to spank their children based on religious beliefs?
- Power: Review the definition of power provided in this chapter. Make a list of the different types of power.
  - What is your own comfort level with the power inherent in child protection work?
  - What, if any, are your concerns with social workers having power over their clients?
- Natural Helpers: Reflecting on your own experience, identify the natural helpers that existed within your own community and/or family.
  - What are the benefits and challenges of working with natural helpers?
  - How difficult would it be for you to work with natural helpers that hold different values from your own? Why?

Additional Resources

- Daley, M. R. (2021). *Rural social work in the 21st century: Serving individuals, families, and communities in the countryside* (2nd ed.). Oxford University Press.
- Oliver, C. (2017). *Strengths-based child protection: Firm, fair, and friendly*. University of Toronto Press.

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Informed Approach to Disclosures of Abuse and Healing

8

Daniel A. Afram and Amber Miners

The authors are located in Iqaluit, Nunavut but their respective work covers the Qikiqtaaluk region of Nunavut.

Consistent with other remote Indigenous communities, social work in Nunavut has many unique challenges and limitations. The current chapter aims to explore and understand approaches to these challenges, through the introduction of a case study highlighting common realities across Nunavut. We will further describe several practice approaches and competencies in navigating the case study. As social workers, we must understand the historical and social complexities of Inuit populations to consider any approach or intervention in the provision of service. It is our hope that the introduction of Inuit history and its context will enrich your approach to care within our region. We introduce and explain the Child Advocacy Centre (CAC) model, which works within the Inuit Qaujimajatuqangit (IQ) principles. We will also explain the Umingmak CAC and how its introduction has changed the response to childhood trauma within our jurisdiction, and allowed for more inter-departmental communication and collaboration. This change has ultimately shifted the response to care of our most vulnerable children and adolescents in our community.

This chapter will review Inuit history, values, community response to supporting children and adolescents with disclosures, as well as challenges, barriers and interventions. Although the content may seem extensive, we recognize that it may still not feel complete in capturing the complexity of social work in Nunavut. As a future social worker, you need to immerse yourself in the content while maintaining a critical lens of the larger impact of colonialism on service provision. The chapter might also illicit certain reactions based on your own social location and your beliefs about how service delivery should look or be implemented. If you find yourself challenged at certain moments, manage the discomfort as you are able and then return to the chapter when you are ready.

Learning Objectives

By the end of this chapter, you will have the opportunity to:

- Understand the historical context of Inuit in the Arctic
- To be introduced to Inuit societal values
- To explore best practices in community response to care
- To describe Child Advocacy Centres, and the first Child Advocacy Centre in Nunavut
- To recognize the importance of working in multidisciplinary teams
- To explore ethical considerations, barriers and challenges in the context of providing social work in Northern Canada

Inuit history from pre-colonialism to current realities will be reviewed. We acknowledge that we are not Inuit and do not represent Inuit. We write about Inuit culture and heritage only to assist in the description of unique social work practice in our location. We encourage you to look to Inuit organizations and individuals for further information on this subject. Our intention is to provide some foundational understanding relating to themes of distrust in service provision caused by colonialism. Inuit societal values will be explored in the context of resilience and the sustaining of Inuit traditions. Inuit societal values are integral to policy enactment and subsequently service provision. The review of values will add another layer of learning about the strength of Inuit. As an emerging social worker, your understanding of a community response to care is integral to service provision. At times, you may feel disconnected from the theory as realities of practice crystalize; you are encouraged to challenge your learning during this process. We will review community response to care in our Inuit community and the complexity of service provision. Child Advocacy Centres (CAC) have been transformative in many communities with respect to service provision for children and adolescents who have disclosed distinct forms of maltreatment. Therefore, we will review the history of CACs and the impact in communities, particularly Nunavut.

A part of Inuit societal values relates to working together for a common good. This value is explored through a discussion about working in multidisciplinary teams. As social workers we are actively confronted with ethical dilemmas, and these can be unique in remote communities such as Nunavut where your neighbour might also be your client. Attention to ethical considerations in small communities will be explored. We will conclude our learning by discussing barriers and challenges experienced by social workers in Nunavut. In particular, the section will highlight some of the progress relating to service delivery but will also review a call to action in highlighting the challenges ahead. Prior to our learning on Inuit history, to provide additional context to social work in Nunavut, please review the case study of Jessica, which will guide this chapter.

Case Study of Jessica

This fictitious case study of Jessica will focus on the realities of remote communities, such as service pathways for those located in Nunavut. The authors aim to highlight specific challenges faced as a result of this context.

Jessica is a 10-year-old Inuk girl who is currently in grade 5 in Kinngait, Nunavut. Jessica has three younger siblings and resides with them and her mother (Tapisa) within a multigenerational household that is owned by her Uncle (Jamesie); there are 11 people residing in the three bedroom home. Tapisa has a history of alcohol dependence but in the past year has focused on her personal healing. The former partner (Peter) of Tapisa died by suicide when Jessica was 5 years old.

A couple of years ago, Tapisa started working as a machine operator for a mining company. Tapisa works in another fly-in community on a three week rotation and then is home for three weeks. During the time Tapisa is away working, Jessica and her siblings are cared for by extended family members within the home.

During a recent outburst in the home by Jessica, Tapisa took her daughter aside to help regulate her. Jessica disclosed to her mother that she was being sexually abused by one of her uncles during the period that Tapisa was working at the mining company. Jessica pointed to pain in her vaginal area. Tapisa was very shocked and emotional with her daughter. Tapisa reassured her daughter that she was safe, thanked her for telling her, and assured her that she would deal with it.

Tapisa took Jessica to the Community Health Centre (clinic in the community) where a nurse examined her. Based on the examination and disclosure, a decision was made to fly Jessica to Iqaluit, Nunavut, for additional medical attention and support. Iqaluit has the only hospital in the region. Prior to leaving, Child Protection became involved, in addition to the Royal Canadian Mounted Police (RCMP) being notified of the disclosure.

Jessica and her mother had two hours to get ready before the plane came. Tapisa ran home to get a couple of personal items for her daughter before the arrival of the medevac (emergency medical flight). Typically, Jessica would have been placed on a regularly scheduled flight, but she had already missed the flight for that day and the next one was not scheduled for another two days. Based on the time sensitivity of examining Jessica and collecting evidence, a decision was made to travel by medevac. Jessica's siblings had to stay with extended family in the home while Tapisa and Jessica were away in Iqaluit. We encourage you to keep this case study in mind when reviewing the next section on Inuit history.

Inuit History

Many Inuit reside in small communities in four northern regions of Canada (Inuit Nunangat) including: Inuvialuit (NWT); Nunatsiavut (Newfoundland and Labrador); Nunavik (Quebec); and Nunavut. About 80 percent of Inuit reside across 53 communities within Nunangat (Inuit Tapiriit Kanatami, 2011). Inuit Nunangat encompasses about 35 percent of Canada's landmass and 50 percent of its coastline (Inuit Tapiriit Kanatami, 2011). According to Inuit Tapiriit Kanatami, it is reported that about 60 percent of Inuit report speaking Inuktut (the Inuit language), and 76 percent of Inuit in Nunavut have Inuktitut as their mother tongue (Government of Canada, 2017). The focus of our chapter will primarily be Nunavummiut (Inuit residing in Nunavut) residing in the Qikiqtaaluq region of Nunavut. The Qikiqtaaluq region consists of 13 fly-in communities.

Pre-Colonialism with Qallunaat (Non-Inuit, Particularly of European Descent)

Consistent with all Indigenous groups at the time, Inuit had a thriving, holistic society and actively met their needs through economic, social organization, and spiritual connections. The economic connections centred on the power of Inuit to meet basic needs of food, shelter and clothing (Arctic Children and Youth Foundation [ACYF], 2018). Within traditional Inuit society and harsh climates, Inuit sustained themselves in their diet by hunting, harvesting and eating all of the animal—this provided a significant source of nutrients and needed sustenance. According to Inuit Tapiriit Kanatami (2011), social organization related to how Inuit organized their relationships with each other (e.g. gender roles, communication protocols, education, leadership, governance, dealing with wrongdoers, etc.) and it was intentional and practiced. The social organization allowed Inuit to have control and agency in day-to-day life. Spiritual practices revolved around the way that Inuit

explained their existence through ideas of higher powers, rules of life, relationship with the natural world, and individuals acting as intermediaries with the spiritual world. There are several key historical events that greatly impacted upon the lives of Inuit, primarily colonialism.

1800s-Early 1900s

Whalers began to come to the area from England, Scotland and the United States, as products such as whale bones for corsets, and whale oil were in high demand (ACYF, 2018). Unlike explorers who were just passing through, whalers visited yearly and therefore had a bigger impact on the life of Inuit. According to the Qikiqtani Inuit Association (2013), whalers drew on Inuit knowledge; they employed, traded with, and socialized with Inuit. The relationship between whalers and Inuit introduced regular trade for things like flour, tobacco, textiles, and other metal tools; music such as square dancing (which Inuit still practice today); and social relationships, including babies born from unions between whalers and Inuit (Qikiqtani Inuit Association, 2013).

The first Hudson Bay Company (HBC) trading post was established in Kimmirut in 1912. This expanded to 100 trading posts in the North West Territories (NWT), although not all were HBC. Due to the influence of the trading posts, Inuit started hunting for trade, not just for food, and people grew more dependent on trade goods such as flour and tobacco. This shift caused families to become more individualistic throughout the North, and is seen as the beginning of the use of "money" for Inuit populations (ACYF, 2018). Inuit became dependent, then, on both money and goods, and when these were in low supply, they turned to government services for support.

Canadian Government and RCMP Impact on Inuit

The Royal Canadian Mounted Police (RCMP) initially came to the north in response to threats to Canadian Arctic sovereignty (American and European traders) in the early 1900s. RCMP began travelling to northern communities to enforce Canadian law. In traditional Inuit society, a system was already in place to deal with individuals who were out of line within the group: those who were troublemakers or who caused threats to others (Karetak, 2013). At that time, decisions would be made by Elders, hunters or the whole camp, for the betterment of the camp, and for the good of the group as a whole. This traditional justice worked for the unique lifestyles of Inuit. Increased confusion was created for Inuit with the involvement of RCMP and the new and unfamiliar ways of the Canadian justice system.

Relocation

At the time of the Cold War, many countries fought for sovereignty to claim the North, and Canada sent the military to the North to claim the land. The federal government moved, through forced relocation, the "Canadian Indians" (Inuit) further north in order to claim that land (Inuit Tapiriit Kanatami, 2004; Inuit Tapiriit Kanatami, 2011). At first, Inuit that moved from the Qikiqtaaluk region to higher latitudes (Grise Fiord) understood that they could return to their home communities if they chose. However, this return did not happen. Other relocations occurred with Inuit from northern Quebec, and many suffered greatly and/or died. Extreme weather, and distinct hunting patterns in the unfamiliar territory was the cause. The relocations created artificial settlements, which then turned into communities. On August 18, 2010 in Inukjuak, Nunavik, John Duncan, who was the Minister of Indian Affairs and Northern Development at the time, apologized on behalf of the Government of Canada for the relocation of Inuit to the High Arctic (Government of Canada, 2010).

Figure 1

Apology Statute in Grise Fiord



Note. Picture of Apology Statute in Grise Fiord one of the most northern communities in the Arctic. Photo by Sarah Clark taken on June 16, 2020.

Tuberculosis in the North 1940s – 1960s

Around 1946, thousands of Inuit across the Canadian North suffered a severe outbreak of tuberculosis (TB). This occurred because of the increase in contact with people from southern Canada and the American military who were stationed in the North. The Canadian government sent a coast guard ship called the C.D. Howe to screen Inuit in the North. Members of the settlements were forced to board the ship and be screened for this and other diseases. However, any individual found to have any signs of TB was not allowed to get off the ship. In this way, children, women, and men of all ages were taken away from their families, and many never returned. The majority of Inuit did not speak English, and the southerners did not speak Inuktut, which affected communication. Inuit would spend an average of two and half years in the hospital due to the tuberculosis outbreak, and during this time, many who had left as children had forgotten their language and crucial survival skills. Most importantly, many individuals had missed out on valuable time with family. Some families to this day do not know the whereabouts of their members who died in TB sanitoriums (Olofsson et al., 2008). As a result, many Inuit lost their traditional connection to land and culture. At one point, one in every seven Inuit were in treatment in the south. By 1970, the long-term hospital treatments slowed the epidemic, but Inuit continue to suffer from TB. On March 8 2019, Prime Minister Justin Trudeau apologized to Inuit for the deliberate mistreatment of Inuit with TB; he committed funding towards travel costs for families who knew where their relatives were buried in addition to funding for marking graves and creating plaques (Government of Canada, 2019).

Residential & Federal Day Schools

Prior to colonialism, Inuit had their own way of educating their children. Because Inuit did not have a writing system, children learned through hands-on experiential learning and oral traditions, including the sharing of legends and stories teaching lessons. Residential schools began in the late 1940s for Inuit, and the children were sent away from their families to attend the schools in places far from their home. If Inuit refused to let their children attend, they would not receive or be eligible for the Federal Family Allowance program—this was the first universal welfare program for families. While attending the school, many children were physically, sexually and mentally abused, could not speak their mother tongue nor were allowed to engage in Inuit practices. The separation of children from their parents during these events severely-affected family attachments, ways of knowing, language, knowledge, communication and the foundation of Inuit kinship society (Healey, 2016). Throughout these atrocities, it was maintained that the schools were present to benefit Aboriginal communities (Macionis & Gerber, 2005). By 1964, 75 percent of Inuit children and youth aged six to 15 were enrolled in the schools (Pauktuutit Inuit Women's Association of Canada, 2007). The children who attended the residential schools lost their identity in many ways. The last residential school in Canada closed in 1996; however, the intergenerational trauma from attending residential school continues today. In 2008, then-Prime Minister Stephen Harper apologized to the victims of residential schools on behalf of the Canadian Government (Government of Canada, 2008).

Dog Slaughter

Dogs played an important role for survival for Inuit (i.e. hunting, travel and protection). In the 1950s and 1960s, it is estimated that 20,000 sled dogs were killed (Qikiqtani Inuit Association, 2013). The slaughter happened all across the Arctic yet was not known as a common occurrence because communities were spread apart, and communication was limited. An Inuit family coming into a town might have had their dog team slaughtered in order to force them to stay in the community. Elders have mentioned that this slaughter could also have been orchestrated to assist the Hudson Bay company (HBC) to sell their skidoos (Qikiqtani Inuit Association, 2013). Eventually, the skidoos replaced sled dogs, and Inuit started living in the communities rather than in small outpost camps. Traditionally, family groups would move to where the hunting was plentiful, but being forced to stay in one area meant that hunting was often less plentiful. Distrust towards the RCMP also began to emerge during this period. On August 14, 2019, then Minister of Crown-Indigenous Relations and Northern Affairs, Carolyn Bennett, apologized on behalf of the government of Canada for

colonial practices imposed on Inuit, including sled dog killings—as well as the forced relocations and family separations—to the Qikiqtani Inuit (an Inuit organization representing the Qikiqtaaluk region) (Government of Canada, 2021).

Figure 2

Training Dog Team in Iqaluit, Nunavut



Note. Picture of Laura Pia Churchill training with her dog team in Iqaluit, Nunavut. Erik Boomer, taken on April 12, 2019.

1970s to the Formation of Nunavut

Over the past century, Inuit have been attempting to regain their culture and identity through the work and advocacy of a multitude of local and national level organizations. The organization towards self-government is one example, and organizations that led that process included: 1971 Indian Brother of the NWT; 1971 Inuit Tapirisat of Canada (currently Inuit Tapariit Kanatami); 1972 Inuit Cultural Institute established; and 1981 Inuit Broadcasting Corporation. At present, Inuit Tapariit Kanatami is recognized as the national voice for Inuit of Canada. The role of Inuit Tapiriit Kanatami since its inception has been to support and advance Inuit right to self-determination and self-governance. Through coordination of Inuit Tapiriit Kanatami and its national committees, Inuit were able to secure inclusion of section 35 into the Canadian Constitution Act of 1982, which affirms First Nation, Metis and Inuit rights (Inuit Tapiriit Kanatami, 2004). Inuit Tapariit Kanatami represents four Inuit land claims organizations in Inuit Nunangat and include: Inuvialuit Regional Corporation, Makivik Corporation, Nunavut Tunngavik Incorporated, and the Nunatsiavut Government.

The Nunavut Land Claims Agreement (NLCA) is a landmark agreement with the federal government, which divided the NWT and created a new territory called “Nunavut.” Nunavut has 28 communities that cover 20 percent of Canada’s landmass and three time zones. Nunavut is separated into three regions (Kitikmeot, Kivaliq and Qikiqtaaluk). It came into being on April 1, 1999. The Legislature began with 19 Members of the Legislative Assembly (MLAs). The government is a consensus government, working for agreement among all its members that respected Inuit Qaujimajatuqangit (IQ) values (Government of Nunavut, 2007).

The incorporation of Inuit Qaujimajatuqangit (IQ) values into every aspect of modern-day practices within Nunavut exists to maintain and enrich the cultural heritage of Inuit. IQ values are therefore central to Inuit way of living and self-determination. The following IQ values are not only integral to the way of being in Nunavut but also encompass service provisions, such as providing service as a social worker.

Inuit Qaujimajatuqangit (IQ values)

1. Inuuqatigiitsiarniq: Respecting others, relationships, and caring for people:
2. Tunnaganariq: Fostering good spirits by being open, welcoming, and inclusive:
3. Pijitsirniq: Serving and providing for family and/or community
4. Aajiiqatigiinniq: Decision making through discussion and consensus
5. Pilimmaksarniq/Pijariuqsarniq: Development of skills through observation, mentoring, practice, and effort
6. Piliriqatigiinniq/Ikajuqtigiinniq: Working together for a common cause.
7. Qanuqtuurniq: Being innovative and resourceful (i.e. in solving problems)
8. Avatittinnik Kamatsiarniq: Respect and care for the land, animals and the environment

(Government of Nunavut, 2007)

The incorporation of IQ values into service mandates and programming is helping shift the way systems respond in supporting individuals and families within Nunavut. The complex history of Inuit reviewed in the previous section of this chapter has led to intergenerational trauma. Intergenerational or historical trauma refers to trauma experienced by past generations that continues to have an impact on descendants (Crawford, 2013). In many Indigenous communities, such as Nunavut, the presence and impact of intergenerational trauma is commonplace. In recognizing this intergenerational trauma, several initiatives and groups have been working towards a model of service delivery to the most vulnerable segments of the population. The incorporation of IQ values is central to providing appropriate provision of care, as it recognizes the importance of Inuit principles in addressing historical harm. As we transition to our case study, it is important to be mindful of the themes and concepts learned in the previous sections. The application of the previous learning will aid in our perspective with respect to providing care and support to the fictional young Jessica and her family.

Community Response to Care

In this section of the chapter, we will describe the local approach and support given to children and families like those identified in the case study. In the previous section we learned of the history of Inuit through colonialism and the role of national organizations in elevating Inuit voices. Furthermore, the introduction and incorporation of IQ values into programs and services is gradually changing the relationships that community members have to these services. For example, the initial contact for Jessica, following her disclosure, is important as her connection would not have been possible without services explicitly embracing IQ values. Rooted in IQ values is the Surusinut Ikajuqtigiit protocol. The application of this protocol in Nunavut has been able to shift how service providers support the most vulnerable children and adolescents in the community.

Surusinut Ikajuqtigiit (A Group Helping Children)

Based on generations of mistrust from governmental services and entities, forming meaningful relationships is crucial in remote communities such as Nunavut. Traditionally, the basis of strong relationships in Inuit culture has typically related to connection to family, friends and community with a level of equity. The sustained resilience of many Inuit can be attributed to horizontal ties, by which individuals have equal membership and there is reciprocity and cooperation. Vertical ties are relationships in which a member has greater standing with respect to authority, knowledge and wisdom (Brown, 2020). Increasingly, as southerners and governments use vertical ties in their relationship to Nunavut, the sense of belonging and acceptance for Nunavummiut becomes revoked. Vertical ties can be instrumental in some aspects of social work practice; however, when the power balance misaligns, it can become detrimental to the culture, values, and rhythm of the community. Therefore, any collaboration must adhere to traditional community principles as a priority, and must be both reflective and reflexive of generational harm inflicted on individuals and communities by southerners. As social workers, we need to be mindful of the distinction between horizontal and vertical ties. An equitable relationship at the horizontal level can eventually inform the expertise that may be sought at the vertical level.

The creation of Surusinut Ikajuqtigiit (SI) policy as led by governmental departments in Nunavut, is based on the eight IQ values identified earlier in this chapter. Surusinut Ikajuqtigiit recognizes the importance of collaboration (Piliriqatigiinniq—working together for a common cause) within the care provided to the most vulnerable populations. The policy was achieved through active collaboration with governmental organizations who are normally responsible for the care, safety, and education of children and adolescents. The collaboration between these governmental departments, non-governmental organizations, and Elders responding to the needs of the child/adolescent and family is the foundation of SI by protecting children and ensuring that their voices are heard. SI emphasizes the need for multi-disciplinary approaches, collaborative and responsive practices, promotion of child-centred and strength-based investigations, and support services to children and youth. Without the collaboration of community members and important policies as laid out in SI, the creation of coordinated services such as Child Advocacy Centres would not exist (Government of Nunavut, 2020).

The incorporation of SI and IQ values are examples of appropriate connection between horizontal and vertical ties. Simply, if there had not been significant engagement at the horizontal level through engagement and relationship building, it would be very difficult for the community to have embraced other systems. Similarly, the creation and success of Child Advocacy Centres (CACs) is attributed to an appreciation of ties. Without one service provider willing to acknowledge their limitations to another organization with mutual interests, services would be fragmented, and would not take into account the best interest of an individual or community.

Child and Youth Advocacy Centres

Child Advocacy Centres (CACs) or Child and Youth Advocacy Centres (CYACs) exist in support of children and youth who have experienced different forms of abuse/maltreatment (Hickey, 2015). CACs/CYACs provide child-centred environments for the person receiving support. Although the CAC model may have variations across regions, it is recognized as an overall best practice model of care for response to child/adolescent abuse (Bertrand et al., 2018). The Centres are created out of a need to improve disjointed service collaboration and lack of child-centred processes, which inevitably causes more trauma to a child after abuse/maltreatment. As highlighted in Table 1, CAC/CYACs have been shown to have many short- and long-term benefits (Bertrand et. al., 2018; Herbert & Bromfield, 2016).

Table 1

Benefits of CACs

Short Term Benefits	Long Term Benefits
• Increased mental health services and referrals • Increased access to medical consultations • Improved client satisfaction and supports for all parties • Reduced number of interviews • Increased data collection	• Decrease impact of Adverse Childhood Experiences (ACES) • Decrease incidences of risky health-related behaviours • Decrease impact of systemic trauma • Resources dedicated to improving response, community outreach • Increased understanding of big picture

Note. Adapted from Herbert and Bromfield, 2016.

CACs in Nunavut

It is reported that child abuse and maltreatment rates in Nunavut are approximately 10 times that of the national average (Representative of Children and Youth, 2019). The stark difference in these rates has resulted in a demonstrated need for improved service coordination in Nunavut to support children and adolescents. Based on a community needs assessment, it was determined that a CAC would provide supports using a child-centered, culturally-relevant response to young Nunavummiut (people residing within Nunavut) who have experienced child abuse and neglect (Qaujigiartiit Health Research Centre, 2010). The embracing of a CAC in Nunavut was encouraged through service partners in the creation of the SI.

With the non-governmental organization (NGO) Arctic Children and Youth Foundation (ACYF) as lead, the following organizations and departments were involved in the collaboration: Justice, Health, Education, Child and Family Services, the RCMP, and Nunavut Tunngavik Incorporated (NTI). These organizations signed a memorandum of understanding (MOU). An MOU is an agreement between distinct parties with mutually-accepted expectations. The expectation was the commitment of the highlighted parties to create a CAC in Nunavut where children and their families can feel safe and comfortable to access support.

The Umingmak Centre became operational in 2019 in Iqaluit, Nunavut. Since opening, the Umingmak Centre has provided services and resources to children and families where there have been disclosures or suspicions of crime relating to abuse (i.e. exposure to significant caregiver violence, death and homicide, sexual abuse, neglect and physical abuse). The Centre uses best practice in child abuse investigations, assessment, support and treatment by coordinating with its service partners (e.g. RCMP, Child and Family Services, Pediatricians, Justice, Education and allied community members).

Umingmak is the Inuktitut word for muskox. Umingmaks are known to be very protective of their young. When a young umingmak is in danger, the adults create a protective barrier around them to shield them from harm. The analogy of protection is rooted in the purpose of the centre and community values around caring for vulnerable children and adolescents.

Figure 3

Umingmak Centre



Note. The images show the various components of the Umingmak Centre. Photos taken by Kaity Inookee and Emma Akulukjuk-Hackett on September 18, 2021.

The Umingmak Centre has highly skilled professionals who provide quality service through a trauma informed lens with children/adolescents and their families.

Roles at the Centre

To help describe how a CAC works, and how it might serve the needs of someone like Jessica in our case study, we will describe the role of each member of the team at the CAC.

Child/Adolescent Advocates at the Umingmak Centre are responsible for supporting children/adolescents, and their non-offending caregivers with age specific trauma informed support. Advocates are the main point of contact for children and non-offending caregivers. They are ultimate service and system navigators following the completion of the interview or investigative process and are a source of psychoeducation to families and children/adolescents.

The role of the *Inuit-trained Counsellors* at the Centre is to support families, children/adolescents through trauma-informed information and supports. The Inuit counsellors utilize a combination of both western and culturally based approaches. The counsellors also practice from the perspective of IQ principles. Counselling can occur in the context of individual, family and group formats. Given the disruptive nature of trauma in a family setting, family therapy allows individuals to incorporate the various available resources. With cultural and individual family considerations, family therapy can include whoever the child/adolescent views as a supportive person. Counselling can be tailored to individual needs.

The Umingmak Centre works closely with local *Pediatricians.* The role of the pediatrician is to provide clinical support in the investigative process, and to complete a forensic examination (collect DNA samples from child/adolescent for testing and provide essential medical care). Pediatricians also provide reassurance examination for cases where there has been a historical disclosure (disclosure that occurred outside clinical limits for examination). They also meet with the child/adolescent and their non-offending caregiver as needed in order to provide follow-up care. The Centre works closely with specially trained *RCMP Interviewers* in child/adolescent cases of maltreatment called the Specialized Investigation Team (SIT). The SIT was formed in 2019 as part of the Nunavut RCMP V Division. The SIT is focused on assisting and conducting investigation of sexual crimes involving children and adolescents across the territory of Nunavut. The officers will typically conduct their interview in plain civilian clothing to reduce stress and intimidation possibly triggered by the uniform. For many children/adolescents who have been interviewed at the Centre, it is typically the first time seeing an officer in civilian clothing. The interviewer's role is to acquire as much information relating to the disclosure as possible in order to determine if a charge can be made.

The role of the *Child Protection Worker* is essential to the investigative process of the particular allegation/charge, and ongoing after that time as needed, to ensure the safety of the child/adolescent. Protection Workers are also known as Social Workers within Nunavut. Protection Worker will typically bring the family to the Centre observe the interview for further interventions and provide support as well. Simultaneously observing the interview eliminates the need for further interviews which might be distressing or retraumatizing.

Case Study and Multidisciplinary Care

Now that we have reviewed the history of Inuit in Nunavut and the CAC model, we can look at how this multidisciplinary care would look for Jessica from our case study. We will review the steps and process of investigation typically followed in Nunavut, as well as the start of healing for Jessica and her family. We learned earlier that the creation of the Surusinut Ikajuqtigiit (SI) policy was to encourage collaboration following disclosures of abuse. Disclosures of childhood sexual abuse within Nunavut typically are received through Child Protection Services and the RCMP. As part of the SI, there is an emphasis on the importance of community partners ensuring that their efforts to protect children from abuse are integrated, effective, and culturally appropriate.

Each of the smaller communities in Nunavut has a Community Health Centre (CHC). Community Health Centres provide a variety of health services (i.e. emergency, pre-and post-natal, immunizations, public health, counselling, mental health and etc.) and are typically supported by community members and nurses. In the Qikiqtaaluk region, physicians typically fly into the community on a rotational basis every few weeks. Nursing staff connect with physicians via phone or email (depending on urgency) to best support clients locally. For more complicated or urgent cases, the individual is flown to Iqaluit via scheduled flights or medevac (air ambulance).

In this fictitious case of Jessica, her disclosure activated different reporting agencies within her community of Kinngait. Upon being examined by the Community Health Nurse (CHN) at the Health Centre, the CHN had to contact Child Protection Services as part of her *Duty to Report*, as well as the RCMP. As we have previously learned, Child Protection is responsible for the safety of the child/adolescent and will determine if the child needs protection, whereas the RCMP investigates to determine if criminal charges are to be laid.

Due to the time sensitivity in the case of Jessica, the CHN sought direction from the physician who was on call in Iqaluit. Based on the physician consultation, the decision was made to have Jessica flown to Iqaluit for further care. A full investigation was not possible in the community due to the timing of the scheduled plane arrival, so both Child Protection Services and the RCMP made sure to connect with counterparts in Iqaluit.

Jessica Arrives in Iqaluit

In the case study focusing on Jessica, arrangements were made with Child Protection Services to provide the family with transportation at the airport. As the flight arrived late, the Child Protection Worker ensured that the family was taken to the local medical hotel/boarding home for individuals and families visiting Iqaluit for medical care. Arrangements were subsequently made with Jessica and her mother to be picked up in the morning to come to the Umingmak Centre.

Upon arriving at the Umingmak Centre, Jessica and her mother Tapisa were welcomed by the Advocate who is Inuk (singular for Inuit). At the onset of the therapeutic relationship, the Advocate typically provides a tour of the Centre to the child/adolescent and their non-offending caregiver, as was the case for Jessica and Tapisa. The Advocate reinforces the existing supports and highlights that the Centre is dedicated in building community relationships and resources to help families throughout the journey from disclosure to healing.

Often country food (food that is local to Inuit) and beverages are offered and shared during this time, which is consistent with Inuit culture. The experience can at times be quite overwhelming for non-offending caregivers as many caregivers are flooded with emotions about their own past traumatic experiences. As we learned earlier in this chapter, the impact of intergenerational trauma is pervasive within northern communities. Being in supportive spaces like the Centre can at times result in many caregivers disclosing their own experience of abuse (typically sexual maltreatment) during the introduction meeting with their child/adolescent. Caregivers of children/youth involved with the Umingmak centre have been universally thankful for the existence of services through the Centre for their child/adolescent, but often talk about the contrast in the potential impact that the Centre's existence would have had within their own adult lives and healing had it existed for them during their childhood. As needed, the Centre typically connect caregivers to an Inuit Trained Trauma Counsellor.

Specialized Investigative Team (SIT)

Jessica was introduced to two female members of the RCMP SIT who conducted her interview. Typically, one will lead the interview and the other will monitor the interview in another room along with the Child Protection Worker. Jessica is bilingual (fluent in Inuktitut and English), but preferred to be interviewed in English, and therefore was interviewed by an English-speaking interviewer.

In the event that Jessica was unilingual in Inuktitut, an Inuktitut speaking RCMP member would have taken the lead on the interview, or an interpreter would have been provided. In Nunavut, there has been significant recognition for the need to train additional RCMP officers who are fluent in Inuktitut.

Medical Examination

Jessica was then introduced to the pediatrician. The pediatrician spent time with Jessica and her mother prior to the exam, to allow them to feel comfortable and ask questions. The clinic room is child friendly and is similar to any other clinical exam room in a community health centre or hospital setting. The pediatrician provided a medical assessment, which in this case included a forensic examination and obtaining forensic evidence with a sexual assault evidence kit (SAEK). The specifics around evidence collection were provided by the forensic interview that was completed. With consent, Jessica's mother was present for the entire examination.

Case Review

Following the interview with Jessica, the SIT members met with the pediatrician to review their respective interviews and assessments. In this case, there were significant findings by the pediatrician during the examination. It was also helpful that Tapisa kept Jessica's clothing from the sexual assault which was then sent out for testing. The majority of sexual assault evidence collection is sent to Manitoba to the RCMP national forensic lab for testing. During this review, the SIT lead investigator also confirmed that Jessica gave a disclosure, which resulted in her uncle being arrested and charged.

Following this discussion, the SIT members, pediatrician and advocate met with Tapisa and Jessica to inform them about next steps. Tapisa became emotional after learning about the disclosure and medical findings. Tapisa expressed worries about being evicted from the familial home as it is owned by her brother (the alleged perpetrator). The team attempted reassurance that the support Jessica has received will be a big factor in determining the positive healing journey ahead for her. Victims of sexual abuse have better treatment outcomes if they feel believed by the person they disclose to (Humphreys, 1992; Vaplon, 2015). Tapisa was offered additional support through the Inuk Trained Counsellor and also met with the Child Protection Worker to develop a safety plan.

At this point, an exploration of a treatment plan was reviewed with the multidisciplinary team at the Centre. Typically, for cases within the Qikiqtaaluk region, interdepartmental collaboration occurs and families are supported to travel and have ongoing support in their home community (i.e. Mental Health Nurse, Outreach Worker, Wellness Counsellor and in some cases an Elder).

In the case of Jessica, following the immediate arrest of the uncle, Tapisa, Jessica and their family were evicted from the home. This created an emergency situation of homelessness. According to Inuit Tapiriit Kanatami (2014), about 39 per cent of Inuit in Inuit Nunangat live in overcrowded homes compared to four percent of all Canadians. The significant disparity can create additional stressors and pressures for families fleeing violence. In the case of Jessica, the Protection Worker was able to make arrangements to have Tapisa and her children brought to Iqaluit for emergency housing. Nunavut operates family violence shelters in each of the three regions.

Healing Considerations

The deleterious long-term impact of child maltreatment and trauma for children/adolescents often manifests in the breakdown of family systems and poor psychosocial outcomes (Buss et al., 2015). Within treatment, the goal is recovery for the individual, family and caregivers. At the Umingmak Centre, individual trauma counselling is available for children and youth who meet criteria for counselling along with their non-offending caregivers. The treatment program provides principles of trauma-informed practice which highlight the principles of trust, safety, choice, and control. The goals of the programs are to reduce the negative impacts of abuse, trauma, and maltreatment while fostering resilience. Each client's treatment plan is created collaboratively with the client and the multidisciplinary team, as the ultimate goal is to allow the child to heal holistically in the domain of the physical, developmental, cultural and spiritual self.

Being believed by a non-offending caregiver, following disclosure of abuse, can at times be transformational for the child/adolescent providing the disclosure (Bolen & Lamb, 2004; Humphreys, 1992). Simply, within the therapeutic process, non-offending caregivers possess the ability to play an essential role in supporting their child/adolescent through traumatic disclosures and subsequently the experience itself. In keeping with the importance of familial relationships among Inuit, there is active mobilization of the child's support systems. The additional recognition of the non-offending caregivers highlighting their own historical and sometimes active traumas, can at times complicate the healing journey for the family, particularly the child/adolescent (Manion et al., 1996). The complexities of supporting the family system through a culturally-centric approach in helping members of the family heal in their recovery journey, specifically focusing on the challenges facing the non-offending caregivers and their respective traumas, is quite significant. The role of the Inuit Trained Trauma Counsellors assists in making this work successful

Multidisciplinary teams can be incredibly helpful for families such as Jessica's in navigating their healing journey through the linking of services and resources available within the community. Although, discussion and actions coming from these teams' meetings will look different for every child/family, the collaboration of partners remains essential in better understanding and meeting the needs of each child.

The well-being of children is impossible to separate from the well-being of their caregivers and others within their community (McKenzie et al., 1995). Within the literature it is well understood that non-offending caregiver support typically has four major dimensions: believing the child, protecting the child, emotionally supporting the child, and obtaining resources for the child (Priebe & Göran, 2008). The shame associated with sexual abuse is at times amplified in remote communities such as Nunavut. As the child/adolescent moves through their trauma healing, the objective is to create new narratives which will empower them to reconnect with previous joys and normalcy within their lives and community. Part of this reconnection centres around family and strengthening the bond associated with same. In collaboration with the family, the Centre is actively finding ways of incorporating traditional healing (i.e. on the land programming) to increase the reconnection for the child/adolescent. Additionally, part of the healing includes increasing the child/adolescent's cultural identity through mentorship with the Inuit Advocates at the Centre. For Jessica this includes learning about her own Inuit history through the experience of running a dog team or being part of therapeutic groups with peers who have had similar experiences.

Figure 4

Being on the Land



Note. Healing incorporates the replenishing aspects of being on the land with clients regardless of season. Photo taken in the summer months of August 2020 by Kylie Aglukark.

Levels of Social Work Practice in Nunavut

Now that we have described a case scenario, we will dissect the levels of social work practices in Nunavut, while keeping this case in mind.

At the *micro* level it is important to recognize some of the barriers that individuals and families have to services. Clients like Jessica and her family received a variety of supports including individual, family and group therapy that was individualized to their specific needs. Within this work, clients are actively referred to other services within the community in order to achieve their full potential and healing needs. The involvement or exclusion of families within the therapeutic relationship at the micro level can also instill or breakdown further issues at this level. Being a social worker within a remote community such as Iqaluit is more than simply providing service and linking people to services. The role and responsibility has many important considerations, especially when working with vulnerable populations. Social workers need to be mindful of the generations of harm and the perpetual continuation of this within systems. More importantly the level of power and trust at the micro level needs to be respected and recognized when navigating larger systems with families.

As social workers, our work with clients at the *meso* practice level typically involves participation in working groups and advocacy towards achieving equitable services within the community. An example of this includes the formation of the Arctic Child and Youth Foundation (ACYF), which was founded by community leaders such as the current Governor General of Canada, Mary Simon. In 2003, along with other community members, Mary Simon created the organization ACYF to support children and youth of Nunavut to navigate their quickly changing world from the traditional Inuit way of life. About a decade later, the prevalence of childhood sexual abuse was becoming even more apparent, and leading community members created a working group to address this important issue. The first Child Advocacy Centre (CAC) in Nunavut is an example of the gradual grassroots movements to address community issues at the meso level. Families, like Jessica's, are able to receive coordinated services as a result of organization at the meso level.

Similar to the working group in the meso system, it took a couple of community leaders to focus on changes at the *macro* practice level. As a result of their efforts over the past two decades, change have occurred at the political level by having a Memorandum of Understanding (MOU) created within all the departments in Nunavut who are responsible for the well-being of children, such as Education, Health, Justice, Child and Family Services, the RCMP, and Nunavut Tunngavik Incorporated (NTI). The support of leaders from these departments for this MOU has allowed the opportunity for there to be a focus on children and adolescents in Nunavut to receive the coordinated, consistent care they deserve with respect to adverse experiences such as abuse and maltreatment. The opening and subsequent success of the Umingmak Centre has also encouraged governmental and non-governmental funders to create a second CAC within the Kitikmeot region of Nunavut.

Without the advocacy of social workers, allied professionals and community members doing individual and family interventions and then shinning a light to the important and prevalent issue of child abuse, there would have been no working groups, political will and data collection to support the need of a transformative approach to addressing child abuse in Nunavut. The collaboration of these leaders would not have been possible without the ability to contextualize the issue of abuse and the manifestation of it as evidenced by significant harm inflicted on the community following colonization. Community members actively recognized the impact of the historical harm and transformed it through an adherence to Inuit Qaujimajatuqangit (IQ) values, working collaboratively across sectors for the betterment and future of the most vulnerable populations.

Ethical Considerations for Working in the North

Living and working within a northern, remote setting such as Nunavut makes it challenging for one to truly understand and appreciate the context. Specifically, there is a strong foundation of culture and experience in each community that requires respect from workers who come from outside those communities. Therefore, social workers should be proactive in increasing their overall knowledge, prior to working in such a setting. Furthermore, respect, humility, and openness to learning are essential and the genesis of these principles do not begin once you are in the setting but prior. Professional development allows for this crucial foundation for social workers entering practice in a northern community. Without the provisions outlined in social work codes of ethics, the manner in which professionals conduct themselves could adversely affect not only the worker but the type of work done with vulnerable clients and their families. An adherence to regulated bodies such as a college of social work can ensure that the work is being guided with the best interests of our clients, especially in marginalized and vulnerable communities in Nunavut. In stating this, our clients are left at a disadvantage when we engage in the work without any accountability through connection with a regulated body. Currently, in Nunavut, there is no mandate to be part of a college of social workers, which can lead to concerns especially when the individual is a new graduate. Ideally, a competent social worker is guided by legislation so that they are better able to work within those parameters or possibly challenge policies. When practitioners do not have a professional college to belong to, this can create issues with appropriate checks and balances, which can leave the client in a situation with limited recourse if ethical violations occur. In remote communities such as Nunavut, having a professional college affiliation is essential when considering the history of harm.

Although professional membership is not mandatory, many social work practitioners in Nunavut have opted to be part of the Association of Social Workers in Northern Canada (ASWNC). The ASWNC represents social workers in the Yukon, Northwest Territories and Nunavut. The aim of the Association is to provide support to social workers through professional development and representation at the territorial and national level. The values in the Code of Ethics adhered to by ASWNC follows that of the Canadian Association of Social Workers (2005), which includes: respect for the inherent dignity and worth of persons; pursuit of social justice; service to humanity; integrity in professional practice; confidentiality in professional practice; and competence in professional practice.

The issues that arise in northern social work practice include practicing beyond our competence, dual relationships, having too much access to information, and limited supervision. An additional issue is professional drift which can occur in northern communities where a social worker can abandon the purpose associated with the profession in place of roles associated with other disciplines.

The role of a regulatory body would be to ameliorate the emergence of such issues by keeping social workers within the boundaries of their profession. Although there is no regulatory body within Nunavut, practitioners are still morally obliged to uphold these standards and adhere to these boundaries through membership involvement and appropriate supervision. When practicing in northern and remote communities, the lack of resources or "experts" within communities can result in many social workers engaging in work that is normally outside their expertise, or a practicing social worker might align oneself with the practice of other professionals within the community (Schmidt, 2009). For instance, a social worker might be asked to assist with a role outside their usual scope, simply due to a shortage of staff. Although well intentioned, this alignment may lead to service and care that is not client centred. Social workers who embrace these additional roles for the sake of resource scarcity also risk denying clients their right to feel empowered. Due to the nature of social work practice in the north, we are also privy to more details of our clients' personal lives, as we are neighbours with our clients; we see them at the grocery store and at the hockey rink. This familiarity is not the case in other geographical settings. Truly, the combination of these factors places us in various ethical predicaments.

For social workers in northern practice, appropriate supervision is essential in ensuring that the described challenges are avoided. In balancing a client's right to self-determination along with an ethical dilemma, the role of a culturally-diverse multidisciplinary team is even more important in all decision-making processes.

As social workers, our professional knowledge, insight and experience allow clients to work with us and hopefully trust us. If barriers exist to us upholding that professionalism, this may impact our ability and growth as a social worker, which in turn will negatively impact clients. Any regulatory body for our professional code of ethics is a reference point that allows us to do the work that we are intended to do within this helping profession. Furthermore, our removal from this process, or lack of acknowledgement of the historical context, would be harmful not only to our therapeutic relationships but also to the growth experienced by our clients.

Challenges and Barriers

Geography poses the most significant barrier to families and their ability to access professionals, including social workers. Finances for physical travel are obvious, but the latent barriers geography poses for families are perhaps more dangerous to meaningful access. The implications of Jessica and her caregiver travelling some distance for care outside her home community are significant. Without access to childcare, families with a child/adolescent in need of medical practitioner care, as well as care from allied professionals (including social workers) at a Child Advocacy Centre (CAC) may be forced to choose between accompanying the child to the CAC and leaving remaining children in non-ideal child care arrangements or in the temporary care of a child welfare agency. In addition to child care issues, accessing care may mean parents are forced to choose between taking unpaid leave from work and forgoing wages needed to feed and house their families. As social workers in remote communities, we need to be aware of these realities, as they provide essential context to any client intervention and goal setting. Awareness of these realities also ensures that we manage our expectations of our clients by not asking too much of them.

The reality of the case of Jessica highlights many inequities that continue to exist for victims of child abuse and family violence. Limited availability of resources typically means that the victim has to relocate in order to access support. In some instances, the abuse is maintained and perpetrated as the victim(s) are unable to leave, and there are no emergency resources within the community. The daunting reality faced by families like Jessica's present additional stressors and systemic barriers for families in their healing. In this situation, following the disclosure, Jessica had to travel out of her home community for additional care and supports. Jessica also learned that, as a result of her disclosure, she and her mother were no longer welcome in their familial home. As the family considered these new changes, Jessica and her siblings also had to consider changes to their home environment, social life and emotional supports. Tapisa also has to be able to navigate new employment and support systems for herself and her family.

The challenges facing the child/adolescent in a remote community in Canada are evident and need to be acknowledged. Southern social workers in remote communities such as Nunavut need to understand the barriers in place and how these barriers may affect children and families. This understanding will help social workers and allied professionals in connecting and supporting families successfully at micro/meso/macro levels. As seen by the progression of grassroots organizations, no social worker or medical practitioner is going to change the world overnight. Rather, the role is to understand and chip away at the challenges that have been cemented through generations of trauma and wrong-doing. Understanding the community, knowing the families and their challenges, understanding the available resources and the lack of resources facing families, and listening to concerns is crucial to transformational and meaningful change.

In addition to understanding children/adolescents, their families, and the communities from which they come, it is extremely important that social workers from the south operate from the perspective of diligently making connections and knowing what resources are locally available. Whether it is the Community Health Nurse (CHN), the Child Protection Worker, a community justice worker, a government representative, or an Elder, such individuals will understand family dynamics, relationships, and any existing trauma far more than someone operating from a stand-alone place of "expertise."

Conclusion

Inuit have lived in the Arctic region for over 5000 years and are the original inhabitants (Inuit Tapiriit Kanatami, 2004). Prior to colonization, Inuit resided in small, family-based camps, and were nomadic, travelling seasonally on the land for hunting, fishing and gathering all their food and resources. To survive the harsh climate, Inuit typically depended on each other to meet their basic physical needs (i.e. food and shelter). Established values sustained families throughout these hardships, and the resilience of Inuit has sustained them over the years. The role of Inuit Qaujimajatuqangit (IQ) values have also been instrumental in the maintenance of culture and identity. Furthermore, the incorporation of IQ values in policies and organizations has proved beneficial in the lives of Inuit, but this is an active process and practice, especially for southerners working in Nunavut with children/adolescents and their respective families.

As experts working in remote communities such as Nunavut, it is our duty to be informed about the histories and oppressions experienced by our clients. The deleterious long-term impact of child maltreatment and trauma for children/adolescents often manifests in the breakdown of family systems and poor psychosocial outcomes (Buss et al., 2015). The discovery of a child experiencing severe maltreatment can cause trauma to each family member, and can have serious implications for the lives of all family members. How a parent responds to a child disclosing abuse can also have a dramatic influence on the child. In a territory such as Nunavut, with a well-documented history of intergenerational trauma, social and physical inequalities, the impact of a disclosure in the family is typically experienced differently in that the dynamic shift can be significant (Representative for Children and Youth, 2019). Multidisciplinary teams can play a significant role in the healing of families, especially when the team is representative of the uniqueness of the community and its needs.

Based on the two decades of commitment towards the realization of the first CAC in Nunavut, it is easy to appreciate the complexity and challenges of historical harm. The Umingmak Centre plays the vital role of supporting children/adolescents with disclosures of abuse (e.g., sexual, physical, neglect and exposure to violence). The multidisciplinary approach is rooted in recognition of cultural perspectives and understanding of the initial disclosure and healing journey. Based on the uniqueness of the remote community, services available to the children and their respective families are fostered and enriched from a cultural perspective by creating allies within the community along with fostering service partnerships.

In supporting a child/adolescent in their healing, family involvement must be central to the child/adolescent's overall recovery. Childhood sexual abuse is relational by nature, and therefore the importance of aligning with families to foster further healing through social learning and corrective narratives has the potential to sustain wellness within families. Increased connection and support is key to increased family empowerment, healing, safety, sense of self and resilience, and reduced generational transmission of trauma response.

Daniel A. Afram: As an African-Canadian social worker, I am aware of my own experiences of oppression and acknowledge this within other spaces of equity deserving people with shared struggles. This encourages me to engage in active reflexivity when working with and within Indigenous communities. My commitment to respecting the values and needs of Inuit, is founded on intentionality, active listening, and ongoing learning.

Amber Miners: I have reflected extensively on my own background and lived experiences. I am cognizant of the advantages and disadvantages these things have had, and continue to have in my life. I am perpetually working towards being more aware of my positionality within my community, the world and most importantly in relation the people I interact with daily.

Activities and Assignments

- If you were to start planning to open a CAC in a northern community close to where you are now, whom would you speak to first, and what would be your priorities in planning? Apply the concepts of micro, meso, macro perspectives to your answer.
- You are starting a new job in Kugluktuk, Nunavut as a social worker. You have recently graduated and are very keen. What do you expect will be your three biggest challenges, and how might you overcome those challenges?

- As part of your self-care, you have joined an extracurricular activity playing frisbee. One of your teammates is a parent of a family that you are involved with at work. How would you navigate this interaction?
- A caregiver you are supporting informs you that she is worried about a case conference at their child's school. How would you apply the Surusinut Ikajuqtigiit in this situation to ease her worries about the meeting?
- This chapter highlighted the many challenges experienced by Jessica in leaving her home community to receive service. As the social worker helping the family with their transition to their new community, which IQ values will you apply to guide this process?

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“It’s All About Context” - Knowing, Not Knowing and Everything In-between

3

Colleen McMillan; Natalie Compagna; and Hilton King

This chapter focuses on unlearning, learning, and understanding why context is paramount before practicing in northern and rural Indigenous Canadian communities. Context is explored and written in this chapter from the worldview narratives of a First Nation social worker, followed by a euro-western educated settler and academic, and lastly a recently graduated social worker living and working in a rural and northern community. These three first-person narratives explore context through historical associations with land, ethics and values, knowledge creation and why reflective and reflexive work is needed for a social worker to practice in northern and rural communities. The practice tensions embedded in these issues between the First Nation and euro-western worldviews are shared through case scenarios that highlight the work needed to ensure the social worker helps rather than harms. We conclude the chapter by offering an “epistemological Wampum Belt” as a transformative way for the two worldviews to move forward, contextually mindful of the uniqueness of rural and northern social work.

Learning Objectives

By the end of this chapter you will have had the opportunity to:

- Appreciate the importance of context as a critical prerequisite for social work practice in rural and northern communities
- Question learned knowledge: identify spaces in one’s learning where harm can be unintentionally reproduced
- Deeply understand oneself and social location regarding western and Indigenous knowledge and how the two intersect in social work practice
- Learn and unlearn, and in the process, come to a place of cultural, contextual, and epistemological humility

“Context starts in the history”: Land Acknowledgements as Relationship

This chapter is collaboratively written from three distinct worldviews: the first narrative is written by an Indigenous person who is a social worker, the second narrative by a euro-western educated academic and social worker, and the final by a recent Master of Social Work graduate working and living in a rural and northern community. We intentionally chose to write in this way to highlight the differences between worldviews and how disconnection among kinds of knowledges can occur and be transferred to a social work practice. We also wrote this way to show that collaboration between different worldviews can be achieved, when guided by core social work values such as respect, diversity, cultural appreciation, and dignity. Lastly, we believe writing this chapter in the more traditional or western way, as in using one “voice,” is disingenuous to the messages we want to share. Understanding different worldviews and exploring Indigenous and euro-western histories represents a critical first step to fully understanding living and working in northern and rural Indigenous communities. A case highlighting tensions and possibilities ends this first section exploring land acknowledgments as relationship, and how navigating these as a social worker working in a rural and northern setting requires intentional unlearning, and then learning, before any help can be offered or received.

Indigenous Narrative of the Relationship with Land

My given name is Hilton King, which is a name that I use to identify myself within society. When I want all of Creation to hear me, I introduce myself in my Ojibway language as Wahmahtig (Learning Tree). This is very important because I want my ancestors to know that I have not forgotten to keep my language strong as it represents who I am. There are very few fluent speakers in my community and as time goes on, I can see how the loss of language, land and displacement of our people affects us socially and spiritually. I come from a small, northern community 300 kms north of Toronto, called the Wasauksing First Nation. The overall population is 1,073 with 379 living on reserve with a land base of 7,874 hectares. Every two years the First Nation holds an election appoints one Chief and five councillors who politically and socially administer the community. The programs and services offered to the First Nation members include day care, a band school, health station, adult learning centre, community centre and an Elders’ residence. Most of my family still reside there with some living off reserve.

In my Creation Story, I know that my name has a big part in my identity. My connection to Creation allows me to be who I am because my name, Wahmatig, (Leaning Tree), is how I am identified in Creation. Had my parents known the teachings of traditional life, my identity would have been nurtured as Anishinaabe. My Creation story has been told within the Mediwiwin Lodge Medicine Society as well as in The Mishomis Book. This Creation story tells of how we came to be as Anishinaabe peoples.

We all have different responsibilities and for me as part of Creation, I believe I am here because this is part of my life journey. In my journey, I attend to spirit by using my medicines and teachings to help me live a good life. My learning has also taught me not to forget how my culture changed my life. Understanding that my spirit was always kind and caring is a huge awareness for me. My Christian training took that away, and I always felt I was not good enough, not lovable enough, and that I would never amount to anything. I can say from the bottom of my heart that my faith in our ways and creation saved me, and I will forever be grateful for who I am.

The Creation Story and the Relationship to Land

Within the Creation story there are seven sacred fires of Creation. Each sacred fire tells of a time in Creation that brought forth life. Each fire is a teaching of how life unfolds from the Creator’s sacred intentions. Each sacred fire tells us of the gradual unfolding of Creation with the first fire speaking to the Creator’s first thoughts and it is from this first fire that we continue today to use shakers in our ceremonies to emulate the Creator’s first thoughts, or the sound of those thoughts. The second fire speaks to the forming of the stars within Creation and then came the moon and sun and duality was formed. This was the third fire in Creation. Each fire signifies the Creator’s work.

Gitchie Manido, also known as the Great Spirit, took four parts of Mother Earth and blew into them using the sacred shell. From the union of the four sacred elements and his breath, man was created. It is said that Gitchie Manido then lowered man to the earth. Man was the last form of life to be placed on Earth. From this original man came the Anishinabe people. The intentions of our life as Anishinaabe people and as the last ones to be formed tells me that we are to help maintain balance and harmony within Creation. Because we were the last to be formed, we must always show our respect for the life that the rest of Creation gives to us, including caring for the land.

The land we have been delegated to live on by the government of Canada is getting smaller as our communities grow by the numbers. There was a time in our history where we had no boundaries and we roamed all over Turtle Island to hunt, gather, build our homes, and raise our families within Creation. We did not abuse the land because we knew that we only had one Mother Earth and it was up to us as the keepers to help her help us to survive here. We realized that if her waters became undrinkable, her air polluted, her back filled with garbage, none of us would survive. Only the animals would survive because they know the teachings of how to live in harmony with Mother Earth.

Since 1492 with the coming of another race to our Island, our lives were changed forever. This was in our prophecy, and it was said that this other race would either bring peace and good will or they would bring a life of hurt and pain to us as a people. As we can see in our history, Indigenous people of Canada have been marred by hurt and pain caused by foreign ways of living. Our ancestors were wise and could see that the other race who came here intended to stay which is why they felt treaties must be developed that respect everyone, particularly the land.

In Canada’s history, they say the Royal Proclamation is the Magna Carta of treaties; however, when this treaty was written there was no input from our leaders. This document also states that we only have the right to use the land, but we cannot own our land. In the Indigenous worldview, the only treaty we recognize and respect is the Wampum Belt Treaty that was developed by all the Nations of Turtle Island under the watchful eye of the Creator. This treaty symbolizes that we all can live together but must respect each other and respect Mother Earth by traditions. There are many Wampum Belt treaties in our history and the Two Row Wampum was the treaty that symbolized that we can all live here and go down the same river, but no one can interfere in each other’s life and how they live. This treaty belt was made physically from all the elements of Creation as opposed to a piece of paper such as the Royal Proclamation.

I am hoping I have given you enough understanding to come to your own conclusion on why this land we walk on is sacred and we must respect her.

Euro-western Narrative of the Relationship with Land

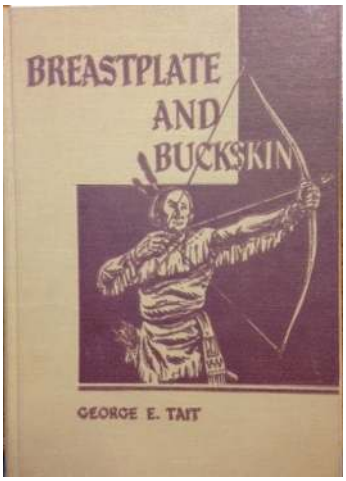
This next section is written from the worldview of a euro-western educated settler who is now an academic in social work. My name is Colleen McMillan and my understanding of the land comes from my primary and secondary education that is informed by a white, settler and colonial version of history.

My primary and secondary education emphasized the conquest of North America by men such as Christopher Columbus, Jacques *Cartier a*nd John Cabot, all who accidentally discovered Canada while seeking a way to Asia. My knowledge of Indigenous people and the land they owned came from several textbooks I was given as a student during the 1970s, including *Building the Canadian Nation*, by George W. Brown, and *Breastplate and Buckskin*, by George E. Tait. The textbook, *Building the Canadian Nation*, was authorized for use in the schools of New Brunswick, Nova Scotia,

and Saskatchewan by the Protestant Committee of the Council of Education. Tait, who authored *Breastplate and Buckskin*, received the McGraw-Hill Ryerson Special Book Award in 1978 for outstanding contribution to Canadian education and as a model of how to present historical educational material on Indigenous life to primary school students.

Figure 1

Breastplate and Buckskin



Note. Canadian history textbook Breastplate and Buckskin by Tait, G.E (1953).

Both textbooks depicted Indigenous peoples as savages who attacked early explorers, making conflict a necessary way of life. The use of witchcraft and a connection to the occult inferred they were to be feared and not trusted.

Figure 2

Breastplate and Buckskin



Note. Indigenous people depicted as savages in front of Cartier.

I was taught in school that land acquisition was negotiated by Indigenous peoples and European explorers. I was told the explorers would need land to establish settlements and the Indigenous peoples were happy to share their land and knowledge. This notion continued for many decades in schools, past my primary and high school education. As recently as 2017, a Canadian textbook for grade three children contained the phrase, "when the European settlers arrived they need land to live on. The First Nations people agreed to move to different areas to make room for the new settlements" (Lee-Shanok, 2017). My primary, secondary and even university education relating to land was that it was willingly given to white settlers by Indigenous peoples in exchange for firearms and tobacco. Rich and abundant resources freely allowed explorers, and later other colonists from Europe, to take as much land as needed for purpose of settlement. I was also taught that treaties were created with good intention and Indigenous peoples greatly benefited from such treaties. My early education instilled in me the worldview of early European explorers as benevolent and kind toward their Indigenous hosts, and any conflict was the result of the latter peoples' not being civilized.

New Social Work Graduate Narrative of the Relationship with Land

You may be wondering what learning about the history of the land and worldviews have to do with social work practice in northern and rural communities. The answer is everything. The history of the land is the context. The differences between Indigenous and euro-western relationships to land is the context. The social work case study will make explicit what unlearning needs to occur before practice can begin in a way that does not reproduce harm. My name is Natalie Compagna, and I am a recent social work graduate from a School of Social Work whose social work program was framed by euro-western pedagogy. My education left me unaware, uninformed, and unprepared for working in a rural and northern Indigenous community.

Case Study Demonstrating the Importance of Unlearning and Learning

During the third year of the Bachelor of Social Work program I moved to a rural and northern community with a population of approximately 580 people. Shortly after moving there, I began working for a Provincial Child Protection Agency that provided services to seven different Indigenous communities in the area. Much of my time was spent trying to connect community members

with more resources and supports. Many of the resources and supports required did not exist in our area so we had to refer people to surrounding communities. There were two available options: a small mountain town forty-five minutes southeast, or a city an hour and a half northwest.

When I began working my assumption was that the general preference would be to travel to the closest community – the mountain town 45 minutes southeast. My first assignment was to help a mother access more resources. When we met, I presented her with options for referrals. She declined every option I presented from the town forty-five minutes away and asked if I could try to find the same options in the city one hour and a half away. In that moment it became clear that I had missed something, and I felt as though I had completely failed the community member. This scenario would repeat itself multiple times before I eventually approached a co-worker, explained the situation, and then asked, "What is the history and context with the local communities?"

The response from my colleague was more complex than I had anticipated, and immediately I wished I had asked sooner. This reflection highlights the importance of unlearning. The land forty-five minutes away was what many people from one of the local First Nations called home before it was appropriated by European settlers. The Nation of people were removed from their homes, the land taken from them, and they were pushed out of the area. Forced to start over, the Nation resiliently rebuilt their community. However, residual tensions between the local community and the community down the highway were still palpable and very much present.

Shifting from a place of knowing to not-knowing, I asked the mother if she would mind telling me about the tensions associated with the community, I had insisted she go to. She shared many stories about the pain related to how poorly she was treated in the other community because she is First Nations. She suggested that the next time I go grocery shopping I truly pay attention to how customer service is delivered based the shopper. Towards the end of the conversation, she stated that many people would rather drive further to be treated equitably and with respect.

Unlearning and learning as a way forward

As highlighted in this case study, history informs context, which then informs social work practice in rural and Indigenous communities. It is ideal that new social workers be given a brochure, "Community-Context & How to be a Good Guest," in order to be well-informed. However, since there is no such brochure, the social worker is responsible for acquiring the necessary information. Although not a brochure, consider the recommended steps below to ensure you begin your practice in a new community in an informed, respectful, and culturally-mindful way.

First Step: Acknowledge you are a guest and are privileged to be there.

If you have moved to a remote or rural northern Indigenous community for a social work position, your first relationship with the land should come from a place of gratitude. It is important to acknowledge that you are a guest on the land and are privileged to be living there. Take time to familiarize yourself with the local landscape. Do not be afraid to venture out into the community and experience what local amenities are offered. Tour around the outlying areas to the north, south, east, and west so that you have a basic understanding of the geography of the area. Next, is a reminder that may seem superfluous, but you should take heed. If you have arrived in a new community with the narrative, "I'm here, I'm going to fix things, I'm going to help, you're welcome," then please pack your bags and leave. People do not need to be "fixed", and you are not a solution (Lamia & Krieger, 2009). Beginning the work with this kind of narrative is guaranteed to mislead you.

Second Step: Get to know the history which informs existing tensions

Entering a new community from a place of not-knowing will serve you well. A place of not-knowing means not making assumptions and being humble in your approach. A good place to start acquiring knowledge is to ask your new co-workers to tell you about the land, the territory, and the history associated with that land. They may have local books, stories, or information to share with you that will serve as useful tools. Ask if there is a local knowledge keeper or community member that you may be able to speak with. Equally important, and this will hopefully become habit, is to ask what gifts or practices are customary if you are seeking knowledge or wisdom from a community member. For example, in some communities it is custom to give a gift of loose tobacco in exchange for the individual's time and knowledge. Getting to know the area and the history of the land will help you in your social work practice. The earlier you can get this information, the easier it may be for you to provide respectful and informed care.

Examples

Reflection Questions about Land:

- What was your first impression when you read the Indigenous and euro-western approaches to the land? Did you feel there was a connection or disconnection between the two sections?
- Do you know what treaty of land you currently live and work on?
- If you were to identify one lesson you need to unlearn prior to practicing in a northern or rural Indigenous community, what would it be, and how would you plan to unlearn it?

Code of Ethics – Tensions Between two Different World Views

Perhaps the greatest divide between western and Indigenous worldviews is that of ethical codes and related behaviours. In fact, from a language perspective, the term "code of ethics" is absent in the Indigenous worldview. Ways of ethically conducting oneself are legislated in the western world, as compared to relational and wholistic in the Indigenous worldview. Generally, codes of ethics in western centered practice are driven by principles of competencies, risks, and interventions, and they are informed by expert opinion. The Indigenous worldview is relational, starting with acknowledging the relationship with Mother Nature as the Creator. Understanding self allows for behaviour that is balanced, grounding personal and professional behaviour in teachings from the Medicine Wheel, Seven Grandfather Teachings, and the Wampum Belt. As you read through this section identify what you see as shared space, or common factors, between Indigenous and euro-western contexts of professional conduct.

Indigenous Narrative of a Code of Ethics

From an Indigenous worldview, a code of ethics is important to keep us accountable as social workers. Approaching a code of ethics from a place of self-reflection is important to become more attuned to the people we are working with. If we are not in a good place ourselves, and have no knowledge of other worldviews, we will experience difficulty in having empathy, a necessary trait if one is to be a helper. If we are not coming from this place of understanding, it is not our fault, as western ways of knowing have never taken the time to unpack a history that dates back to settler arrival on the land we call Turtle Island.

I have been fortunate with my social work education journey, because it has been culturally motivated. The undergraduate and graduate programs I attended highlighted the gaps in western healing, and the areas where my Indigeneity would be helpful as a healer with my people and community. Treaties signed between Indigenous people and settlers made us accountable to ourselves and how we could live together as people. Some of those treaties are the Medicine Wheel, the Seven Grandfather Teachings, and the Wampum Belt.

The Medicine Wheel

The Medicine Wheel teaching is a guide to living, teaching us that if we follow this guide, our connection to Creation will be filled with harmony and balance. If we think of the Medicine Wheel as an actual wheel, the wheel is incomplete if any colours of peoples are missing. This tells us that society has excluded colours from this wheel resulting in an unbalanced wheel, which means we have an unbalanced society. Our history tells us that this understanding is rooted in truth. Exclusion of people because of their skin colour or different beliefs is evident in the prevalence of racism and domination in our society.

Figure 3

The Medicine Wheel



Note. Medicine Wheel from Curve Lake First Nation Cultural Centre, Anishinaabe. (Source: http://www.curvelakeculturalcentre.c...edicine-wheel/)

In Medicine Wheel teachings, everyone has a right to a good life and no one is excluded (Absolon, 1993). The colors in the wheel represent the four colors of men/women: red, yellow, black and white as illustrated in Image 1. There are animals who sit in those directions and deserve the same type of respect we give each other as human beings because we are all part of Creation and are interrelated. A book titled "The Hollow Tree "by Herb Nabigon (2006) is a reading that reflects a wholistic approach to healing and incorporates the four sacred directions that give us meaning in our social work practice. For example, in the east we receive new beginnings, the south is about relationships and summer, the west is about gathering and preparing, and the north is a time for storytelling and rest. Each of these directions applies to an element of our being: spirit, heart, mind and body. Together, these elements create a wholistic and balanced practice.

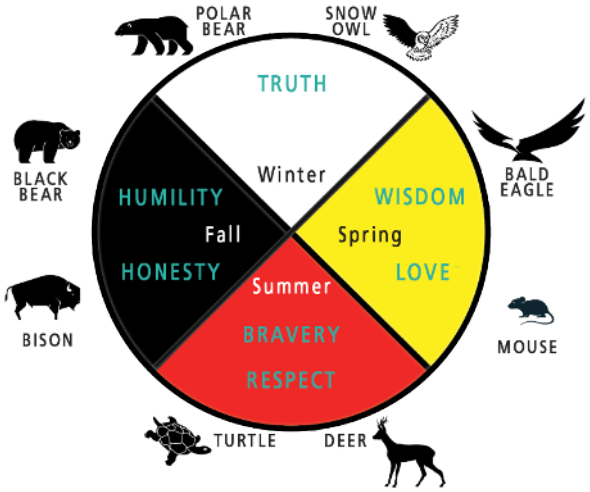
From the beginning of our time, we as Indigenous people knew and respected this worldview as a way of being—not a religion but a way of life. We were instructed to live in harmony and balance within Creation. We were created out of love from Mother Earth, father sky and our grandparents—grandmother moon and grandfather sun.

The Seven Grandfather Teachings

Our belief system is founded upon guiding principles referred to as The Seven Grandfather Teachings seen in Image 2. These teachings guide us on how we should conduct ourselves toward each other and Aki Kwe (Mother Earth). They keep us connected in a way that reminds us that anything we do within the context of Creation, we do always under the guise of Creation to keep us humble. The Seven Grandfather teachings tell us if we do not believe in something, there may be disruptions resulting in a path that is harmful, because we are out of balance and harmony with Creation. Much like the Medicine Wheel teachings, the Seven Grandfather teachings also guide us toward living a good life by following principles; wisdom, love, respect, bravery, honesty, humility and truth. Creator wanted us to live life to the fullest and he/she gave us all the tools to do this, but they all must begin with self.

Figure 4

The Seven Grandfather Teachings



Note. The Severn Grandfather Teachings from the Nottawaseppi Huron Band of the Potawatomi. (Source: https://waseyabek.com/seven-grandfather-teachings/)

Indigenous people believe we experience a state of disharmony or imbalance in our lives because we have strayed away from the teachings of the Seven Grandfathers, fundamentally the lack of respect for self (Rakafa, 2018). Again, the interconnectedness of the Seven Grandfather teachings reflects a synergy between one's core beliefs and one's behaviour or practice; for example, to have truth you must have courage, to have honesty you must be brave, to know love you need to know peace, and to know wisdom you must practice humility. Indigenous people apply these teachings to all of Creation, not just human beings.

The Healing Power of Circle Work

Indigenous authors such as Absolon (2011) Wagamese (2019) and Mitchell (2018) write with spirit about how connected we are to the land, wind, water and sky. We embrace our traditional ways allowing spirit to come and be celebrated, such as when our circles open with ceremony. When spirit is present, we feel supported to be honest, not to be afraid of sharing our personal stories, and to talk openly and with authenticity in circle. As social workers, it is important we also talk honestly in these circles because of the people we are helping. By sharing our own thoughts and insights we allow the pain and suffering of others to be told without judgement or fear of being shamed.

Our circle consists of people from east to west and teachings from those locations. This concept looks at life as circular and emphasizes that everything is related. In Rupert Ross's (2006) book, *Returning to the Teachings*, he explains how the circle can bring harmony and balance back to people who end up in the justice system. He writes that in the legal system there is a winner and a loser, which erects a barrier to healing. In small and rural Indigenous communities this emotional divide is very damaging and creates residual harm. When a circle is used to facilitate conversation between two parties, all people who live in that community are invited to come and participate if they wish. recognising the principle that harm extends beyond the individual. The four sacred

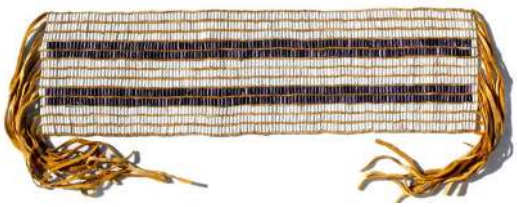
medicines of tobacco, sweetgrass, sage and cedar are placed in the middle of this circle to help bring the spirit of these medicines into the circle. The medicines are placed in their respective direction to honour the belief that ancestors sit in those doorways and can be called to help at any time. A facilitator familiar with Aboriginal beliefs guides the circle aligned with the spiritual component of Indigenous beliefs. An Eagle feather is given to each participant who speaks to support the sharing of truth. The knowledge that is shared validates Indigenous thought, which supports multiple perspectives and truths given through honesty and authenticity. The circle brings people together with a feeling of kinship. I believe this blood memory has taken its place to bind us together.

Teachings of the Wampum Belt

The Two Row Wampum Treaty defines how we are to go down the same river of life together: Indigenous people stay on our side of the river and settlers stay on their side of the river, and we are not to interfere with each other's way of being and knowing. This parallel journey is reflected in Image 3 with the two lines that are equal but do not intersect. Unfortunately, this agreement was never followed although for Indigenous people, our worldview has not changed, and we still believe that all people have an inherent right to a good life.

Figure 5

The Wampum Belt



(Source: https://nationtalk.ca/story/alan-oji...ng-importance- of-wampum-belts)

Corbiere (2014) explains how the Wampum Belt is a symbol of a worldview connected to the land and spirit world and a reminder to settlers of historical agreements. Theses agreements were made under the watchful eye of Creator and acknowledged the sacredness of treaty discussions toward a world that all people live in harmony and balance. Unfortunately, these understandings are no longer acknowledged or followed by settlers and a disconnect from Creation is the result. As with other Indigenous ways of knowing, the Wampum Belt is symbolic of the deep and scared relationship to the land. Indigenous peoples see land as our Mother Earth and do everything in their power to help preserve her.

Euro-Western Narrative of a Code of Ethics

Euro-western codes of ethics for social work have transitioned through several different stages over the last century, suggesting either an evolution or a search for meaning, depending upon one's perspective. Reamer (1998) identified four spans in which the profession's code of ethics can be understood: the morality period, values period, ethical theory and decision-making period, and lastly the risk management period that predominates today, particularly in child welfare. While the morality period reflects the Christian charity or non-profit origins of the social work profession, on organizing relief and responding to the "curse of pauperism" (Paine, 1880, as cited in Reamer, 1998), there remain paternalistic elements within the context of social work and Indigenous peoples.

The period in which the concept of morality dominated was the era of residential school systems (1876-1996). The forceable removal of thousands of First Nations, Métis, and Inuit children from their homes by provincial welfare workers was most evident during the 1960s, also known as the 60s Scoop. The intersection of religion and charity, both concepts underpinning social work ethics, assumed the form of government sponsored religious boarding schools toward the goal of assimilation into euro-Canadian culture (Union of Ontario Indians, 2013). The failure of this government intervention set the context for the 60s Scoop, when social workers assigned to reserves acted as agents of the state in the apprehension of children. Social workers at that time were not required to have specific knowledge about, or training in, Indigenous child welfare or First Nations culture. Trained in the western worldview and supported by a code of ethics that guided their actions, social workers "were not trained to recognize problems rooted in generations of trauma related to the residential schools" (Kawartha-Haliburton Children's Aid Society, n.d., para. 1). Societal views existing at this time were used to justify the systematic disruption of families as necessary through the involvement of social workers; Indigenous peoples were regarded as "child-like creatures in constant need of the paternal care of the government. With guidance, they would gradually abandon their superstitious beliefs and barbaric behaviour and adopt civilization" (Titley, 1992, p. 36). Equipped with "good intentions," child welfare workers, unfamiliar with child-rearing practices and communal values, "attempted to rescue children [without] taking culture and ethnicity into consideration as it was assumed the children would take on the heritage of the foster/adoptive parents" (Alston-O'Conner, 2010). Contributing to the morality stance was that of monetary gain; provincial child welfare organizations received monies for each child apprehended (Lavell-Harvard & Lavell, 2006). The transfer of Canadian Aboriginal children to the United States served as an additional financial gain as private adoption agencies paid child welfare services in the amount of $5,000 to $10,000 per child (Lavell-Harvard & Lavell, 2006). Child welfare policies actively supported social workers to "remove Aboriginal children from their homes and communities and damage Aboriginal culture and traditions all the while claiming to act in the best interest of the child" (Johnson, 1983, p. 24).

Parallel to these activities was the development and expansion of The Canadian Association of Social Workers (CASW), founded in 1926 with the first code of ethics offered in 1938. The initial code was revised eight times since 1938 with the most recent revision in 2005. In Canada, while social work legislation is the responsibility of the provinces/territories, provincial codes of ethics reflect and uphold the values listed by the CASWE to guide social work practice. These include (CASW, 2005):

- Value 1: Respect for the Inherent Dignity and Worth of Persons
- Value 2: Pursuit of Social Justice
- Value 3: Service to Humanity
- Value 4: Integrity in Professional Practice
- Value 5: Confidentiality in Professional Practice
- Value 6: Competence in Professional Practice

Despite the multiple revisions to the CASW Code of Ethics, several scholars have critiqued the code for failing to recognize the historical role of power embedded in the values, with more emphasis placed on protecting the profession than the pursuit of social justice. For example, Collier (1993) considers the relationship between social work and practice in remote and rural areas to be a residual effect of colonization. He argues the social work profession has traditionally reflected control and regulation, serving dominant society's interests of agency bureaucracies, rather than the interests of Indigenous individuals or their communities (Collier, 1993). In a 2010 Master's thesis, Marques (2010) explored to what degree the CASW's six values transferred to practice in northern, rural and remote communities, defined as communities north of the 54th parallel. A key finding of the study that interviewed social workers working in rural and northern communities, including reserves and with band councils, was that the CASW Code of Ethics (2005) did not align with the rural and northern context in which they worked. Value misalignments identified by Marques (2010) in her thesis, "Applying the Canadian Association of Social Workers Code of Ethics in Uniquely Situated Northern Geographical Locations: Are there factors in practice environments that impact adherence to the 2005 code?" are shown in Table 1.

Table 1

Misalignments between CASW Values and their Applicability to Rural and Northern Practice

CASW Value	Value Misalignment
Value 1: Respect for the Inherent Dignity and Worth of Persons	Challenges providing direct service to clients in their home communities – community norms, existing/non-existing community structures/ programs/services, and multi-service collaboration Challenges with the justice system and child welfare system – social justice is not served, political games
Value 2: Pursuit of Social Justice	Limited Resources – lack of positions and funding Service provision in home community – (community leadership challenges, community power structures, accessibility, resources, service provision environment, community supports
Value 4: Integrity in Professional Practice	Social worker role challenges – holding a social work degree, qualified, experienced, competent, specialization expectations Challenges with supervisor role – non-degreed, unqualified, lack of access, lack of support, lack of knowledge Nepotism – power structures, positions provided to unqualified family members and/or friends, impacts the quality-of-service provision, impacts clients directly
Value 5: Confidentiality in Professional Practice	Boundary challenges – dual and multiple roles Confidentiality challenges – professionalism, service environment, privacy, community population, accessibility to community, service provider community-based versus itinerant
Value 6: Competence in Professional Practice	Unrealistic expectations of service provision – beyond area of competence, lack of specialization Geographical location – accessibility, existing services/supports, and jurisdictional challenges

(Marques, 2010)

Christian eurocentric values frame the CASW Code of Ethics (Vanderwoerd, 2010) so it is not surprising that the code's transfer to practice is experienced as problematic and incongruent to the living and working contexts in rural and northern communities. Two foundational concepts of the CASW Code of Ethics have been earmarked by the Ontario Human Rights Commission as problematic in the context of Indigenous children continuing to be overrepresented in the child welfare system: decision making and risk management. Perceived bias of authorities, including child welfare workers, has been reported in decision making practices related to assessment, resulting in higher rates of risk being assigned to Indigenous families. In the report, *Under Suspicion: Concerns about Child Welfare*, The Ontario Federation of Indigenous Friendship Centres have identified that non-Indigenous child welfare workers, do not understand the nature or structure of Indigenous families and cultural differences in how families live. They only see that children are not being raised by their parents or are living in what they think are over-crowded conditions. In another example, Indigenous youth told us that they are sometimes put into care because they miss a lot of school due to practicing their traditions and taking part in ceremonies. (Ontario Human Rights Commission, 2017)

Additionally, risk assessment and tools used to assess risk are perceived to "be biased and perpetuate racism because they do not account for structural inequalities, such as racial discrimination, that may affect a child's well-being" (Ontario Human Rights Commission, 2017). To extend this argument further, structural inequalities leading to poverty are stated to result in value judgements against Indigenous parenting practices by non-Indigenous social workers. Standards for assessment are based upon white, western and Christian worldviews which fail to consider cultural knowledges, values and beliefs.

New Social Work Graduate Narrative of Code of Ethics

An Elder I was working with offered me traditional medicines, and performed a smudge ceremony as a gift for helping her. The Elder explained to me that I owe her a package of tobacco for the medicines. In that moment, the western and Indigenous approaches to value and ethics collided. Professional boundaries in the social worker and client relationship are important. As outlined in the CASW (2005) Code of Ethics, value 4 and principle 3 states, "social workers establish appropriate boundaries in relationships with clients and ensure that the relationship services the needs of clients" (p. 7).

I was not able to call a "time-out" so that I could quickly shuffle through my textbook on how to handle the situation. Furthermore, I did not even know where I could look to inform myself on this situation. In the moment I had to use my judgement and gut instincts. This was not the first Northern Indigenous community that I have worked with, so I knew that a cardinal rule is to never turn down a gift from an Elder as a helper. It would be insulting to the Elder and may harm the working relationship. Farrah (2012) notes that "giving or receiving a gift that extends beyond acceptable gestures, such as a cup of coffee, a meal or a holiday hamper, can change the professional nature of the social worker – client relationship" (p. 4). In the context of the local community, having someone gift me with medicines is not only considered an acceptable gesture, but an honour.

Accepting the gift was resolved, but I still had to contend with the ethical dilemma of presenting the Elder with the gift of tobacco. At this point I had only been working in the area for three months so was not familiar with local traditions. The first step I took was to consult with a supervisor who was from the community and a band member about local traditions, specifically around gift giving for Elders. I was able to maintain confidentiality while presenting the scenario. My supervisor provided me with insights which included the type of tobacco to purchase, where to purchase it, and the best way to present it. She agreed that accepting the gift and providing tobacco was the best course of action.

The immediacy of this interaction straddled me between honouring the CASW Code of Ethics (2005) ingrained in my western framed education, and that of respecting and paying homage to the relational importance of the local Indigenous context. The crux of the situation was how to find possible middle ground between the CASW Code of Ethics while being respectful to Indigenous ways of knowing and living. In practice, I heard colleagues say, "this is the way it is up north" or this is the "northern way." There is truth to this, but we still have ethical obligations and standards as social workers. Finding the path between these two worldviews is contextually bound, requires an openness to unlearn and then learn local ways while being mindful of the legislation that we have agreed to practice by.

Examples

Reflection Questions about Ethics:

- What does ethics mean to you?
- Does this section change how you view the Code of Ethics? If so, in what way?
- How would you adapt your personal and professional code of ethics to local Indigenous culture in the treaty area where you live?

Epistemological Contexts – Multiple Knowledges are Important

Epistemology is a branch of philosophy focusing on the theory and creation of knowledge (Stroll & Martinich, 2021). Willig (2019) argues that a core skill needed to be an effective helper is to have an awareness of one's own epistemological underpinnings, or what kinds of knowledges(s) are valued. For example, does the knowledge that informs one's social work practice comes only from a euro-western worldview, or recognize different forms of knowledge(s) such as those created by Indigenous peoples?

In the same way researchers need to develop awareness of their assumptions about what there is to know and how they can come to know about it (epistemology), social workers need to be aware of their fundamental assumptions about human beings and the world they live in, as well as their beliefs about how best to develop an understanding of their clients and the meaning(s) of their experiences (epistemology) (Willig, 2019).

In this section we will focus on Willig's description of epistemology as it relates to the act or process of counselling in social work. How do you provide counselling? What are you taught about the dimensions associated with counselling; as in where does counselling take place, when does it happen, and what proof exists that it happened?

Indigenous Narrative of Knowledge

Every Nation, community, and individual has their own preferences regarding social work practice. It is essential to recognize that there are multiple ways to provide individual, community-centred and culturally safe services. Otherwise, there is a risk of perpetuating colonized and oppressive approaches that will not provide space for healing but cause more harm (Stewart et. al., 2017). One of the key differences between Indigenous and western practice is the shift from individualistic counselling approaches to more collectivist ways, regardless of whether it represents an individual or community intervention. Some Indigenous worldviews of practice may be indicative of more collectivist societies, such as healing and grief circles. McCormick (2000) notes that more meaning may be provided through community, cultural values, and family. Healing circles are an example of combining all three of these elements.

The way Indigenous peoples approach healing is spiritually guided and mindful of the Seven Grandfather Teachings, the role of the Creator, and beliefs and practices referred to as traditional medicine. The Report of the Royal Commission on Aboriginal Peoples (1996) defined traditional healing as,

Practices designed to promote mental, physical, and spiritual well-being that are based on beliefs which go back to the time before the spread of Western 'scientific' biomedicine. When Indigenous peoples in Canada talk about traditional healing, they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counselling and the accumulated wisdom of Elders. (p. 348)

Traditional healing work is relational, ceremonial, and sacred. There are several avenues that are used to support people who are struggling and in need of healing. Some of the approaches will be described here but it is important to recognize the importance and role of context with each of these approaches. For example, some Nations will use the sweat lodge while others will not. Likewise, some ceremonies associated with the sweat lodge are unique to that particular community. For example, some ceremonies may include drumming and gift offerings to the ancient ones, while in other cases it could be part of a Sun Dance (Marsh et al., 2018). Assuming all Indigenous peoples follow the same healing approaches risks homogenizing people and sacred practices and reproduces colonization.

The Sweat Lodge

The sweat lodge has been used for generations and carries great significance. Those who carry the gift to facilitate this ceremony are ones who have spent many years learning, and can be a woman or man who is trained by Elders to facilitate sweats. They are aware of how sacred this ceremony is because their training has taught them; they know they are dealing with spirit. The ceremony is about purification of the mind, body, and soul and when one goes through this ceremony, they are going back to the beginning when life was safe for them.

Elders teach that the sweat lodge ceremony serves a sacred purpose through the ritual healing or cleansing of body, mind, and spirit while bringing people together to honour the energy of life. I spoke to Elders Julie & Frank Ozawagosh (personal communication, January 2013), about the teachings Elders bring to the Sweat Lodge. The Elders teach that each person who enters the lodge brings his or her own challenges, suffering, conflicts, addiction, and concerns. Sitting together brings connection, truth, harmony, and peace through sweating, praying, drumming, sharing, stories, and singing (Marsh et al., 2018). All the elements of the lodge come from the land and whenever lodges are built, the worldview is that healing will happen, but first faith must be reached by the individual who is asking for healing. Some lodges are envisioned and crafted as circular to represent the Mother's womb, and resembles a baby bump when it is sitting on the land. This is aligned to the stages of life teachings, that talk about how we were carried by our Mother for nine months. In those nine months we were surrounded by water and the heartbeat of our Mother, so if we can borrow from that beautiful image, this is the safest we will ever feel in our lives and provides the ultimate place of security for healing. This author used the sweat lodge for healing from the trauma of sexual abuse while in the care of the Children's Aid Society. My experience in the Sweat Lodge helped me feel that I could trust people again.

Healing Circles

Healing circles, or talking circles, are ceremonies that create space for connection, culture, and healing. When someone passes away in the community there is a collective grief, and the entire community feels the impact of the loss. Coming together, supporting each other in a safe and sacred circle can be powerful. Healing circles take a variety of forms, but a shared element is that members sit in a circle to consider a problem or a question (Mehl-Madrona & Mainguy, 2014). First Nations peoples observe that the circle is a dominant symbol in nature and has come to represent wholeness, completion, and the cycles of life, including the cycle of human communication.

Indigenous healing using circle work starts with a prayer, usually by the person convening the circle, or by an Elder, if an Elder is involved. The way the circle is conducted speaks to the collectivist nature of Indigenous epistemology. This is reflected by the circle keeper saying only few things about the talking object and then passing the object to the person on the left, clockwise. As a healing circle, smudging will often begin the ceremony, to invite the spirit world in and feel connected. Someone will typically go around the circle holding the abalone shell with the medicine and an eagle feather in their right hand. Each person in the circle smudges. A talking stick or other representative object is held by the person who speaks. Other sacred objects may also be used, including eagle feathers and fans, a sacred shell, stone, or Wampum Belt.

Figure 6

Sweet Grass and Feather Used for Smudging Ceremony



(Source: https://f.hubspotusercontent10.net/h...-Brad-Hart.pdf)

Respecting knowledge is multiple, experienced differently for each person, and listening is important for healing; only the individual holding the talking stick speaks whiles others remain in respectful silence. The circle is complete when the stick passes around the circle one complete time without anyone speaking out of turn. The talking circle prevents reactive communication and directly responsive communication, and it fosters deeper listening and reflection in conversation. It also provides a means for people who are prohibited from speaking directly to each other because of various social taboos to speak and be heard. The sacredness of circle work follows Indigenous epistemology in that it honours respectful silence, speaking from the heart, authenticity of emotion and speech, and confidentiality in the circle. Nothing leaves the circle without permission from the speaker.

Time and Place

Time assumes a different meaning when counselling in northern and rural communities. Counselling sessions may be as short as thirty minutes, or as long as an hour and a half if the person you are working with deems it to be important. Allowance is needed to make space for the natural story telling process to unfold, honouring the oral tradition of experience, and not be restricted by the western view of counselling regimes and practice protocols.

Lastly, an office setting may not be appropriate. It is difficult to create a sense of safety in a space that represents generations of systemic racism and biases experienced by Indigenous peoples. Counselling is relational, contextual, familial and land based. Locations of conversations can be determined by the individual and can look like sitting by a fire, going for a walk by the river, or having a cup of tea at a kitchen table. A connection that is not forced, and feels more organic, has more potential to create a space for healing.

Euro-western Narrative of Knowledge

Individuals planning a career in social work practice are met with several mid-level theories of counselling, estimated to be between 200 to 400, to choose from (Lambert et al., 2004). Western approaches to counselling traditionally create foci of practice by organizing theories into different groupings; psychodynamic theories, cognitive- behavioral theories, humanistic theories, feminist theories, and postmodern theories. Organizing theories this way represents a western classification system that is discrete. There is no acknowledgement of context, or how the theories relate to the land or the community. The dimensions relating to counselling emphasize location, duration, treatment protocol and documentation. These dimensions are standardized, apart from feminist practice that is aligned to power dynamics and the relational and reciprocal aspect of the client/worker relationship.

Historically, students enrolled in schools of social work informed by western theories were taught that the problem lies within the individual. A shift during the early 2000s witnessed a shift to a strengths-based perspective. As described by Saleebey (2009), the "fundamental premise [of strengths based social work] is that individuals do better when they are helped to identify, recognize, and use the strengths and resources available in themselves and their environment" (p. 234). Despite this shift, there continues to be a disregard for Indigenous epistemologies in program curriculum. Looking at some of the ways current ontology and epistemology is taught and practiced highlights the reproduction of euro-western centric thinking.

Location of Counselling

Counsellors are often taught to hold sessions in offices or other spaces within a building. If not in an office specifically designated for counselling, then counselling is typically held in an agency, school, shelter or hospital. Counselling in an office is usually one hour in length, after which the individual, couple or family leave. Studies suggest the ideal space with respect to furniture, lighting, artwork, and seating (Devlin & Nasar, 2012; DeAngelis, 2017). In an article titled, "Healing by Design," DeAngelis (2017) states that

> *a good therapy office design should take into account the human instinct to protect ourselves and our territory—a feature that may be particularly important to consider with vulnerable therapy clients. We are animals, after all, and do our best mental work when we feel a little bit protected. (p. 56)*

This concept of protection relates to the social worker, not to the client, and continues to be emphasized as important as evidenced by the recent literature. In the context of working with Indigenous peoples, the historical violence done by the social work profession is unrefuted. Suggesting that social workers need to protect ourselves and our territory is reminiscent of settler narratives inferring Indigenous peoples were "dangerous savages" (Garcia, 1978) and the guarding of appropriated land is still necessary.

Other literature supports the use of credentials in the room to demonstrate the social worker's expertise (Devlin et al., 2009), noting that four to nine displays of professional credentials is sufficient to showcase within the office. The authors were unable to locate any academic western informed literature that included the importance of land acknowledgment in the offices of social workers, especially during this historical moment in the context of the Truth and Reconciliation Report in Canada. The absence of such literature in academia speaks to the erasure of the importance of settler acknowledgement, thus reproducing western dominated ontology of counselling.

Risk and Safety

The concepts of safety and risk are reflected in how social workers are instructed to practice and carry out their respective roles and responsibilities. Much has been written and taught on risks associated with the profession (McCafferty & Taylor, 2020) specifically in the field of child welfare. Despite the growing awareness of harms caused to Indigenous children and families as identified in the report, "Understanding Risk in Social Work" (2017), support continues for "robust assessment tools [to] provide a necessary check and balance in emotionally demanding work" (p. 376). In this way protection of the social worker is central, not the individual or family client. As noted earlier, risk is a concept that permeates throughout much of western social work literature, ranging from office arrangements, to assessments, to documentation. Barsky (2010) states that the continuing rationale for risk management and related policies is to avoid the legal consequences of causing harm, which include lawsuits, disciplinary action, or damage to the employer's legal status or position in the community. This principle is operationalized in how Schools of Social Work teach students documentation that is risk as compared to strengths based.

The emergence of evidence-based practice modalities, such as cognitive behaviour therapy (CBT) and dialectical behavioural therapy (DBT), removes land and environmental context from counselling and reinforces the *problem is the person* argument. Such modalities reinforce a standardized approach to understanding issues experienced by the individual and are divorced from historical, social and environmental impacts such as intergenerational trauma and residential schools. Documentation resulting from such modalities is categorical and discrete, separating personal narratives of the client to be included in case notes.

New Social Work Graduate Narrative Regarding Knowledges

I quickly noticed as a new social work graduate that the space between a euro-western approach to counselling and the Indigenous centrality of relationship within Indigenous communities is evident. This difference first became obvious to me in my role as a Mental Health and Addictions Clinician for a mobile support team; I needed to unlearn what I was taught just a year earlier in a graduate social work program.

As a service provider in a small northern community, no work of any kind can be done without trust. A deep trust must be earned. All interactions are relational, and some may even be experienced as more "casual." or informal. For example, community members have asked me to have tea to decide whether the element of trust is even possible, before deciding to engage in counselling. I have been asked to meet in parking lots to engage in conversations to determine whether I can be trusted.

This chapter emphasizes the importance of context. How context is translated into the ontology of counselling is that previous history of service providers determines what counselling is and how the community understands it. There may be a history of service providers coming into their small town, "helping" for a short time, and then leaving, with this cycle repeated multiple times. There may be residual hurt and pain from this cycle established by previous service providers. All context matters, as it actively informs the number and degree of barriers local community members associate with the concept of counselling.

The examples given in this section relate to the context of counselling, but also apply to any area of practice or focus under the social work umbrella. Before engaging in any type of social work, one must first start to think about community. It will be difficult to become a part of the community and trusted by the community if you do not engage with it. Become a part of the community by being present, engaging in relationship building, and being visible so people have an opportunity to get to know you. If this is out of your comfort zone, or not something that was ever taught to you in school, consider "non-traditional" western ways in which people in the community can determine whether they can trust you in counselling. For example, I do Ride and Rant.

Ride and Rant is my way of adapting to the trust needs of community members. A couple of community members were not comfortable with meeting in the office setting. I advocated funding to purchase Tim Horton's gift cards and then offered to pick people up from their home, grab a coffee and go for a ride. One client who I had seen in the office the first two sessions spoke twice as much in the vehicle. My car has proven to be a valuable and context appropriate therapeutic setting. People appreciate facing the same direction as a sign of relational equality.

Social work in a northern context is about the space created to reflect relationship. Going for a walk in the woods, being outside on the land, talking while walking, sitting by a fire, all symbolize respect for the context of northern Indigenous communities. I sat with an Elder in her garden to have a counselling session because that was her happy place, during a particularly difficult day. Euro-western approaches to working with community members may feel inauthentic, lacking in relational connection and hierarchal because of the physical location in which most social workers are taught to practice in, the office.

Examples

Reflection Questions about Knowledge:

- How did you come to know what social work is? How do you know what you have learned is true?
- Does the way you practice social work support or diminish Indigenous epistemologies? Can you provide an example?
- How would you change your current way of counselling to meet the contextual needs of the community you are working in?
- How do you establish a relationship with the community to empower individual members?

Moving Forward – Creating an Epistemological Wampum Belt

In this final section we offer a way of moving forward that honours Indigenous worldviews while curating western ways of working that contribute and support social workers employed in rural and northern communities. This section is framed by the teachings held in the Wampum Belt. As previously noted, the Wampum Belt is a symbol of a worldview that is connected to the land and spirit world and a reminder to settlers of historical responsibilities, which has taken on greater significance since the discovery of the residential school graves. The importance of context has been a constant thread throughout this chapter, and as social workers we need to reflect upon past harms against Indigenous peoples. A first step is to acknowledge Indigenous knowledges as valid and not less than euro-western knowledge.

In this final section of the chapter, we offer hope to you, by suggesting a social work Wampum Belt informed by Indigenous and western knowledges and worldviews that can be contextually appropriate, mindful, and healing.

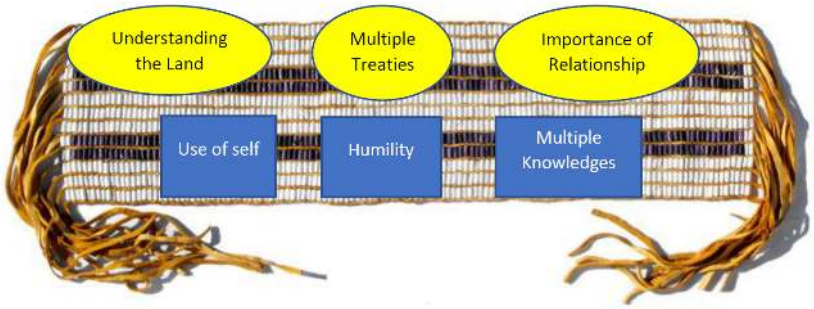
The Two Row Wampum Belt

The Two Row Wampum Belt (Kaswentha) of the Haudenosaunee is an example of a wampum belt that symbolizes an agreement of mutual respect and peace between the Haudenosaunee and European settlers. The principles were embodied in the belt by virtue of its design: two rows of purple wampum beads on a background of white beads represent a canoe and a European ship. The parallel paths represent the rules governing the behaviour of the Indigenous and European peoples. The Kaswentha stipulates that neither group will force their laws, traditions, customs or language on each other, but will coexist peacefully as each group follows their own path (ahnationtalk, 2015; Gadacz, 2020).

Remaining faithful to the teachings embedded in the wampum belt, while continuing to be reflective and reflexive of context, we created a version of the Two Row Wampum Belt recognizing the western learnings and unlearnings that are necessary to provide mindful guidance to those wanting to practice social work in northern or rural communities. For example, social workers trained in western knowledge first need to unlearn teachings related to the land, treaties, and relationships. Only then can learning happen related to the use of self, the importance of humility and respect for multiple knowledges.

Figure 7

Combined Worldview Two Row Wampum Belt



Indigenous Teachings and Western Competencies Wampum Belt

Aligned with the Two Row Wampum Belt, we envision parallel, distinct but complementary, concepts of Indigenous and western knowledges of social work that acknowledge the importance of context while providing mindful attention to practice. This "social work Wampum Belt"' is meant to be sufficiently fluid to reflect local teachings and knowledges specific to treaties, geographies and land issues. We have intentionally allowed space in each of the components to incorporate meanings that speak to the different cultural and geographic contexts found in northern and rural Indigenous communities. Lastly, we want to avoid the prescriptive nature reflective of western social work practice that has become the norm in so many programs, and more generally within the counselling field. That said, we are providing a series of guided questions to deepen and extend self exploration toward an understanding of how to work in northern and rural communities. It is our hope that the following set of questions support your journey in creating a Wampum Belt that reflects and respects the living and working context you inhabit. We suggest that you use your answers to create a Wampum Belt specific to the context in which you live and work to practice in a respectful, authentic and relational way in your social work journey.

Land

What is the territory you live on?

What is the history of the land you live and work on?

How should you be acknowledging the land when speaking?

Treaty

What treaty does the Nation belong to?

What is the history of the treaty you live and work on?

Who belongs to the treaty?

Relationships

What languages are spoken in the community?

What language/languages are taught in the schools?

If there is more than one Nation of people living on the land, what is the history between the two? What is the context?

Humility

How does your social location impact how you may be perceived? Consider the context and history of the community.

Have you engaged with the community and made an effort to be a community member?

Dual Knowledges

What have you done to learn more about local culture, traditions, and etiquette?

How have you adapted your practice to be more community-centred?

What changes need to be made to meet the needs of the community?

Use of Self

What are your hidden biases?

What work have you done to engage in self-reflection?

Are you aware of your social identity?

Moving Forward

It is important, and contextually imperative, that we take a moment to acknowledge the ongoing discovery of children's remains at former residential school across Canada. This discovery underscores the importance of understanding context within social work practice. Those who enter the social work profession do so because of the desire to help, advocate, and make positive changes. The pre-requisite for any change when working in northern, rural areas is to come equipped with an understanding of how this country came to be; how history impacts you as the helper; and how history impacts the people you will be serving. In closing, we are including an interview with an individual who was a career child welfare worker in a rural, northern community to share his lessons and the importance of understanding and accepting context as a key principle. You cannot be a catalyst for change if you do not fully understand how context determines everything and requires unlearning and learning, as well as the space between the two.

Conclusion

This chapter focuses on the importance of context in relation to land, code of ethics and what is considered knowledge for social workers who practice in northern and rural Indigenous communities. Written from the worldviews of an Indigenous social worker, a euro-western educated social worker and academic, and a new social work graduate who lives and works in a northern and rural

community, we emphasize the importance of unlearning what one knows, or has been taught, and the resulting lack of knowledge as a starting place. Unlearning requires understanding historical context and how this context informs current social work practice. We end the chapter using the traditional treaty representation of a Wampum Belt to show how Indigenous knowledge and euro-western knowledge can co-exist in harmony when guided by respect, humility, and acknowledgment of context.

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Older Adults in Rural Communities: Policy and Practice

12

Bonnie Jeffery and Laurie Schmidt

This chapter will discuss the unique situation of older adults living in rural communities and the specific role that generalist social workers play at different levels of practice. Social workers frequently work with older adults in many different roles; this work can include assisting those who are moving from their homes into settings such as long-term care facilities. However, a large proportion of those over the age of 65 continue to live healthy and productive lives in their own homes and communities. It is the latter group that is the primary focus of this chapter, in which we explore what rural social workers can do to support successful aging in place for community-dwelling older adults.

In order to set the context we first present information on the current profile of rural older adults in Canada and particularly in Saskatchewan. We then discuss the concept of ageism which is fundamental to anti-oppressive social work values and practice with this population. This information helps to highlight the important role that social workers play in supporting the needs of this group with a focus on those who live in rural settings. We conclude with a discussion of social work policies and interventions at levels of rural social work practice: practice that is guided by a person-in-environment approach. We highlight the role of a social ecological framework to address the discussion of interventions at micro, mezzo and macro levels of rural social work practice.

Learning Objectives

By the end of this chapter you will have had the opportunity to:

- Understand the unique context and needs of older adults living in rural areas
- Understand how an anti-oppressive and social justice approach contributes to a person-centered approach in rural social work with older adults
- Identify how a social ecological framework that incorporates levels of social work practice supports successful aging for rural older adults

Profile of Older Adults

Canada's population is undergoing a significant shift that will bring both opportunities and challenges. Canadians 65 years and older now make up 19% of the country's population (Statistics Canada, 2022a). It is projected that by 2030 older adults will make up 25% of the Canadian population. Older adults make significant contributions to our society and they play an important role in communities, families, and in the workforce. It is important that we understand the needs of older adults in our country and, as the older adult population increases, that we ensure resources and policies will support these needs.

Older Adults in Canada and Saskatchewan

In 2021, 7,021,430 Canadians were aged 65 or older. This represents an 18.3% increase in the population of this age cohort since 2016: the second-largest increase recorded in the past 75 years, following the increase recorded between 2011 and 2016 (Statistics Canada, 2022a). This rate is also higher than Canada's 5.2% overall population growth rate between 2016 and 2021 (Statistics Canada, 2022b). The 2016 Census was the first time that Canadians aged 65 and older exceeded the number of children under 15 years old. In 2021, there were just over one million more Canadians aged 65 and older than children under 15. The number of children in Canada grew at a rate six times slower than the number of Canadians 65 and older (Statistics Canada, 2022a).

In 2021, 197,985 Saskatchewan residents were 65 or older. Members of this age cohort increased by 16.2% since 2016 (Statistics Canada, 2022c), significantly above the province's overall population growth rate of 3.1% during that same time period (Saskatchewan Bureau of Statistics, 2022). Residents 65 and older now make up 17.5% of the Saskatchewan population (Statistics Canada, 2022c).

Older Adults in Rural Areas in Canada and Saskatchewan

In 2021, 6.6 million Canadians resided in rural areas, an increase of 0.4% from 2016 (Statistics Canada, 2022d). Population aging in rural Canada is occurring at a faster rate than aging in small and large urban centres. There was a 3.1% increase in the population of residents aged 65 and older in rural areas between 2016 and 2021, while urban areas saw a 1.9% increase in that cohort during that same time period (Statistics Canada, 2022a).

In 2021, 79,128 residents in rural Saskatchewan were aged 65 and older, an increase of 10.9% since 2016. This age group now accounts for 20% of the rural population in the province. While overall the rural population has been decreasing in Saskatchewan since 2015, the number of rural residents aged 65 and older has been increasing since 2011, when older adults made up just 16.8% of rural residents.

In summary, the Canadian population is aging. The number of people age 65 and older has increased steadily since 2011. The rural population in this age cohort have also been increasing since 2011, particularly in Saskatchewan where 20% of the population is 65 and older. An aging population presents numerous opportunities and challenges that need to be managed effectively to ensure the needs of this population are supported, through allocation of resources and implementation of health and social policies. Older adults contribute significantly to their communities, families, and friends. With the growing number of aging adults, particularly in rural communities where resources are limited, it is essential that we understand the specific circumstances that rural communities are facing.

Fundamentals of Social Work Practice with Older Adults

Social work practice is guided by a commitment to social justice that incorporates an anti-oppressive approach to working with individuals, groups and communities. When working with older adults it is essential that social workers understand and acknowledge the role that ageism plays when providing supports for older adults.

Another fundamental approach that guides generalist practice is to acknowledge the role of the environment; in social work we consider this a person-in-environment approach. We will provide an overview of the person-in-environment approach and then link this approach to a more specific discussion of micro, mezzo and macro social work interventions through the application of the social ecological framework.

Ageism

The concept of ageism was first defined by gerontologist Robert Butler in 1969. Butler considered ageism to be a form of prejudice by one age group against another, typically expressed by middle-aged adults against youth and older persons. He noted that these groups tended to be characterized as “dependent” on the middle-aged, disempowering the old and the young in a way that was comparable to sexism, racism, and other forms of discrimination. Butler viewed the effects of ageism through an intersectional lens, as he believed that its effects often compounded with other forms of discrimination to increase the impact on a marginalized person’s life (Ayalon & Tesch-Römer, 2018). This point has been supported in later research, which showed that ageism is often faced most intensely by women, the poor, people with dementia, racialized people, and people with less education (Ayalon & Tesch-Römer, 2017; Chang et al., 2020). In future work, Butler refined the concept of ageism to be a set of positive or negative attitudes, behaviours, institutional practices, and policies aimed at older adults (Ayalon & Tesch-Römer, 2018). This later definition of ageism is generally what is meant by discussing ageism today, as popular discourse on the topic tends to focus solely on biases against older adults.

Ageism manifests itself at the micro, mezzo, and macro-levels. At the micro level, ageism is developed and maintained by individuals’ thoughts, emotions, and beliefs about a particular age group. At the mezzo level, groups, organizations, and other social entities’ beliefs and actions towards age groups reinforce ageism. Macro-level ageism is created through a culture or society’s values towards specific age groups. Each of these levels assists in the production of self-directed and other-directed ageism (Ayalon & Tesch-Römer, 2018).

Additional research has found that the prevalence of ageism within a society is correlated with an increased prevalence of older adults (Marques et al., 2020; Ng & Lim-So, 2021). Also, other-directed ageism is associated with cultural anxiety related to aging and a fear of death within a society (Marques et al., 2020). The more meaningful contact people have with older adults, such as spending time with older family members, the less likely they are to hold ageist attitudes (Marques et al., 2020).

As previously noted, ageism can be self-directed or directed towards others (Marques et al., 2020). When directed outwards, the effects of ageism are most commonly seen and studied in healthcare and in the workforce. Often, this ageism is implicit, and is therefore difficult to address (São José et al., 2019). Older adults are often characterized as a “drain” on the healthcare system, which may help to propagate ageist attitudes in the system (Ayalon & Tesch-Römer, 2017). Negative stereotypes about older adults may lead medical professionals to believe that their older patients cannot handle the same treatments their younger ones can (São

José et al., 2019). Older patients are also more likely to be kept out of their own treatment decisions and spoken to patronizingly or disrespectfully by medical personnel (Ayalon & Tesch-Römer, 2017).

Self-directed ageism is also commonly seen in healthcare, as older adults may refuse treatment because they view themselves as too old, or they may not receive treatment for ailments they believe are simply a part of the aging process (São José et al., 2019). Such attitudes and behaviours tend to lead to poor health, memory, cognitive performance, and work performance outcomes for older adults (Marques et al., 2020). Self-directed ageist attitudes are associated with increased morbidity and mortality (Ayalon & Tesch-Römer, 2017). Even when older adults face "compassionate" ageist attitudes, such as unwanted help or paternalistic treatment, negative health outcomes and inward-focused ageism are likely to be produced (Vervaecke & Meisner, 2021).

Older adults are often faced with ageist attitudes and stereotypes in employment. Older workers are seen as more costly and less productive than their younger counterparts. They are also the most likely to get fired first and have the greatest difficulty finding employment in poor economic conditions (Ayalon & Tesch-Römer, 2017). These phenomena are exacerbated for women, who are seen as reaching their "peak" as workers by age 35, which has negative impacts on their prospects for promotion and employment (Krekula et al., 2018). Workforce ageism also has been shown to predict poor health outcomes, such as depression and long-term illness (Chang et al., 2020).

It seems likely that every person who reaches old age will face ageism; its scope is significantly broader than other forms of discrimination (Ayalon & Tesch-Römer, 2018). This makes ageism a significant policy and practice issue that needs to be addressed in order to support aging populations. Given that the values and practice of social work are based on anti-oppressive approaches, it is critical to address ageist attitudes. By focusing on a person-in-environment perspective social workers can address these attitudes at multiple levels of practice.

Person-in-Environment Approach to Supporting Rural Older Adults

Person-in-environment is a principle that guides social workers in the practice of their profession. This principle focuses on how a person's environmental context affects their behaviour or self. The environment, understood within the framework of person-in-environment, consists of a person's social, economic, political, communal, historical, religious, physical, cultural and familial context. The principle also considers how an individual has an impact on their environment (Kondrat, 2013). Thus, in summary, the principle of person-in-environment is that in order to truly understand a person, one must look at the interplay between an individual and their environment.

Person-in-environment was first established as a guiding principle of practice in 1955, when the National Association of Social Workers created a study group to define social work practice (Kondrat, 2013). Following its establishment, it remained the defining feature of social work practice throughout the 20th century (Green & McDermott, 2010). Yet, within that time period up until the modern day, many refinements and advances have been made to the theory and practice of person-in-environment. The 1970s saw the advancement of two leading person-in-environment-adjacent theories: general systems theory and ecological systems theory (Kondrat, 2013).

General Systems Theory

General systems theory was the leading theoretical approach to person-in-environment up until the late 1970s (Kondrat, 2013). It was established from the work of an Austrian theoretical biologist named Ludwig von Bertalanffy, who believed that an element was best understood in relation to its constituent parts (its subsystem) and in relation to the larger or more complex elements that it was a constituent part of. He identified two types of systems or sets of elements: closed systems that are isolated from their environment and open systems that are in constant interaction with their environment. He also highlighted the concept of a subsystem, constituent elements of a larger system placed in hierarchical order, and feedback, the flow of information within an open system that produces change or stability in relation to other systems. Bertalanffy's concept of a hierarchy of systems was invaluable to the general systems approach to social work. People and systems were seen as influenced by the larger systems of which they were a part. This meant that social work practice should emphasize the transaction between a person and systems in the environment (Kondrat, 2013).

However, some theorists believed that general systems theory was flawed, specifically due to the absence of values and ideology in its model, its implicit acceptance of finding homeostasis for an individual (thus making it less than useful to address larger social change or conflict), its abstract model being distant from real life human phenomena, and its focus on transactions between systems being at odds with social work's commitment to person-centred work (Kondrat, 2013).

Ecological Systems Theory

Following the decline of general systems theory, ecological systems theory became the leading theoretical approach to person-in-environment. It aimed to create a more cohesive definition of theory and practice for social work (Green & McDermott, 2010). Ecological theory builds upon general systems theory and ecological science, the study of live organisms within their environment. It is most associated with Carel B. Germain and Alex Gitterman (Kondrat, 2013). Germain and Gitterman conceptualized the environment as made up of social, natural, and built features. Social environments are made up of human groupings (e.g. networks, neighbourhoods, societies, etc.), while built and natural environments are made up of physical features of the world around an individual (e.g. buildings, other living organisms, landscapes, the climate, etc.) (Rogge & Cox, 2001). In ecological systems theory, a person cannot be accurately understood apart from their environment, as they are in an interdependent relationship with their environment and the elements that make it up. It is believed that a person's environment can facilitate or inhibit their well-being, while individuals can also impact their environment in positive or negative ways (Kondrat, 2013).

Ecological systems theory was seen as preferable to general systems theory as its root within the life sciences gave it a more concrete way of theorizing the person-in-environment perspective. It focused on the mutual relationship between persons and their environment more than general systems theory and also viewed the understanding of humans within their environmental context as crucial, rather than simply emphasized as it is under general systems theory (Kondrat, 2013). Yet, ecological systems theory has been critiqued for failing to recognize the unique place of humans as, in ecological systems theory, the individual is portrayed simply as a system among and within other systems. This also means that it fails to pay significant attention to aspects of the personal, cultural, social, physical environments where humans live (Kondrat, 2013).

While these two theories are generally understood to be the main ways in which person-in-environment is conceptualized, there is a broad variety of approaches to understand and practice the perspective across the profession of social work. For instance, what constitutes an environment according to person-in-environment differs depending on one's theory of preference and over time. Many scholars believe that person-in-environment has been primarily applied to interpersonal and social interactions of clients, or that the natural environment is often left out of person-in-environment in practice (Rogge & Cox, 2001). Some scholars even believe that social workers should not identify just one theory to conceptualize social work practice (Kondrat, 2013).

Person-in-Environment and Rural Older Adults

When the principle of person-in-environment is applied to work with older adults in rural areas, several key themes arise. In line with the definition, the primary theme identified was that the fit of older adults within their rural communities depends upon the resources of the person and their community (Keating & Eales, 2012; Keating et al., 2013). Within this broad theme, two subthemes are highlighted: an individual's resources to live a healthy life and environmental factors that facilitate an individual's living a healthy life.

Wealthy individuals are generally found to live healthier lives than their poorer counterparts (Park et al., 2017; Thissen & Droogleever Fortuijn, 2021; Wang et al., 2018). These older adults had the resources they needed to live active lives and access necessary services as well as to engage in the community around them. They also had access to transportation to reach services that were not provided in their communities of residence, something of importance when considering persons living in rural settings. These resources meant that they could devote their time to pursuits that gave them satisfaction, such as community work or building large and strong social networks (Keating et al., 2013). On the other hand, poorer individuals found it more difficult to live healthy lives. This is influenced by the fact that poorer individuals are often marginalized by other facets of their lives; poor individuals are more likely to be older, single, non-white women, who have less education, lower quality of housing and neighbourhood safety, have problems with active daily living, and have a greater number of chronic conditions (Park et al., 2017).

The research identified some environmental factors that mediated older adults' ability to lead healthy lives; the first is communities with strong social networks (Keating et al., 2013; Urbaniak & Walsh, 2021). When individuals lived in communities with strong social networks, they were more likely to live healthy lives. This factor interacts with the personal features of the individual within the environment. For instance, older adults who had lived in their communities for long periods of time experienced a better fit within their community (Thissen & Droogleever Fortuijn, 2021). This connection helps to mediate some of the issues faced by poor individuals in rural communities, as long-term neighbours can watch out for and assist with problems the individual may be facing (Keating & Eales, 2012). Poor older adults living in communities with fewer resources reported a stronger sense of camaraderie, which meant that citizens would help each other to ensure that their needs were met (Keating et al., 2013). Even rural-dwelling

individuals from other marginalized communities, such as LGBTQ+ older adults, reported a strong sense of well-being because of the tight social networks they had built within their community (Rowan et al., 2013).

Alternatively, a community that lacked services needed by many older adults, such as healthcare, had the opposite effect on individuals' well-being. Some of the communities in the literature surveyed were quite remote from urban centres, which meant that older adults had to travel further to access goods and services (Braimah & Rosenberg, 2021). A lack of services had a pronounced impact on the most vulnerable seniors, as they were less prone to travel outside of their community to fulfill their needs (Keating & Eales, 2012). Older adults are at increased risk of experiencing social isolation when residing in rural communities that have high unemployment rates or are far away from urban centres where their children may be living (Keating & Eales, 2012). A lack of familial supports may mean that an older adult needs to look elsewhere for support with tasks and chores in the home (Braimah & Rosenberg, 2021). These older adults may benefit from living in senior housing, as its supportive environment, in part, compensates for the barriers they face as they age (Park et al., 2017).

The literature also noted the importance of understanding changes in personal and environmental characteristics over time. The older a person became, the poorer their person-environment fit was on aggregate (Thissen & Droogleever Fortuijn, 2021). Neighbourhood characteristics in several of the rural communities studied in the literature changed dramatically as the residents' demographics changed. Keating et al. (2013) noted that members of a rural Nova Scotia community who had lived there for long periods of time became newly-marginalized as a result of wealthier residents moving in and increasing the cost of living. This is important information to consider when contextualized with Thissen and Droogleever Fortuijn's (2021) findings that population growth of older adults was most prevalent in key and relatively rich villages due to the housing opportunities and available facilities. They also found that over time, the person-environment fit between wealthy and poor older adults in relatively rich and poor communities changed, as each community type developed to fit a specific group of residents. Changes in an older adult's life, such as the onset of an illness or becoming a caregiver for a spouse or relative, also had impacts on individuals' levels of comfort within their community or the ability to manage stressful situations they had previously managed (Gibson et al., 2018).

Ongoing work to assess the person-environment-fit to understand the lived experiences of rural older adults should focus on particular gaps in the existing literature. Longitudinal studies of older adults living in rural communities may expose valuable information about the dynamic nature of people and their environments. Statistical data may be useful to supplement this, particularly focusing on the changing demographics and economic conditions of rural communities where older adults traditionally reside. In and out-migration of youth within these communities is another feature that could expose valuable insights about family networks and supports available to older adults. Qualitative studies that gauge the interactions older adults have within their environments, specifically related to service use, may also be relevant.

In order to highlight the specific role of social work with rural older adults we now turn to the social ecological framework as a way to discuss potential policy and practice issues at various levels of practice.

Social Ecological Model

The social ecological model can be used as a guide for social workers whose rural practice includes older adults. Urie Bronfenbrenner, a Russian-American psychologist, described individual behaviour as a complex system of relationships that is affected by multiple levels of the surrounding environment. In particular, Bronfenbrenner proposed that the environment had a direct influence on the behaviour and development of a child. Bronfenbrenner's model included five systems: microsystem, mesosystem, exosystem, macrosystem, and the chronosystem.

The microsystem is the closest, direct relationships that surround the individual. It includes relationships and interactions that an individual has with their immediate surroundings such as people in the family, school, neighborhood, or other close settings. The mesosystem is the next closest influence that connects structures such as the connection between home, schools, religious organizations, or neighborhood to the microsystem. The exosystem includes indirect factors in the larger social system, where the individual does not necessarily play a role such as a workplace, industry, media, or government—but that may positively or negatively influence the individual. The macrosystem is the outermost level of the individual's environment that includes cultural beliefs, values, customs, and laws. The dominant beliefs and ideologies of the individual has an impact on all other systems. The chronosystem is the final level. It reflects the cumulative experiences a person has over the course of their lifetime such as a death or physiological changes such as aging. As people age, they may react differently to environmental changes.

In the 1980's, Bronfenbrenner's model, used mainly to explain behaviour, was modified by McLeroy et al. (1988) as the social ecological model, to promote health and prevent disease among the general population. McLeroy et al. adapted the model to five sources of influence: Intrapersonal, Interpersonal, Institutional, Community, and Public Policy (see Figure 1) which were used to guide the development of interventions. The intrapersonal (individual) level includes beliefs, values, education, skills and other individual factors. The interpersonal level includes relationships between individuals. The organizational level pertains to how institutions are organized and managed. The community level includes the networks, associations, neighborhoods, and attitudes among different institutions within communities. The policy level refers to policies and regulations that affect the individual and organizations they function within.

Figure 1

The Social Ecological Model



Note. Adapted from "An Ecological Perspective on Health Promotion Programs," by K.R. McLeroy, D. Bibeau, A. Steckler, and K. Glanz, 1988, Health Education Quarterly, 15(4), p. 351-377.

In the 1990's, Stokols (1996), refined the social ecological model to four levels: individual, interpersonal, community and society (see Figure 2) and identified four assumptions concerning the interrelations among environmental conditions and human behavior.

The first level, the individual or intrapersonal level consists of factors such as knowledge and attitudes, beliefs and perceptions, skills and abilities as well as the individual's age, sex, level of education, socioeconomic status, employment and self-efficacy. At this level, strategies to affect change in behaviour may include education, counselling and mentoring programs.

The next level in the model is the social or intrapersonal, which has a significant influence on the individual's behaviour. The social environment that surrounds the individual consists of the relationships, culture, and society in which the individual is part of. For example, factors in this level may include family and social support networks, spouse or partner, peers, organizations such as schools, workplaces or community organizations that the individual is involved in. Also included in this level is the community culture, norms and socioeconomic status. Strategies affecting behaviour change at this level are intended to promote positive community attitudes and raise awareness. These may include community education, support groups, peer programs, workplace wellness initiatives and social media campaigns.

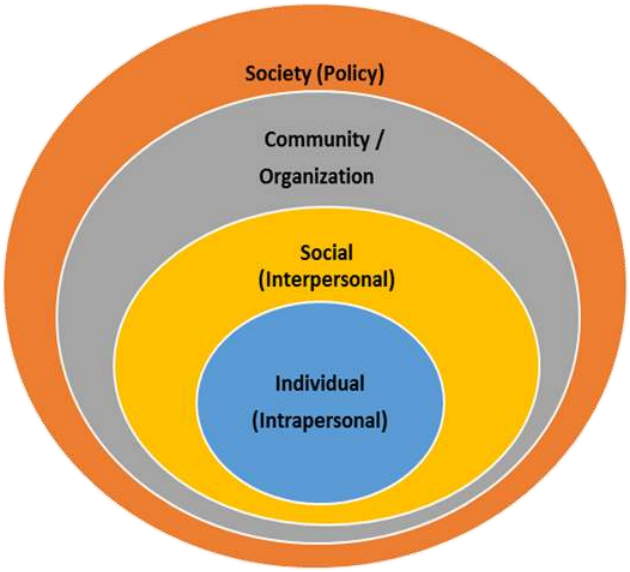
The third level consists of community or organizational factors, sometimes referred to as the physical environment in which the individual lives. The physical environment consists of both the natural environment and the built environment. Factors may include weather, geography, availability and accessibility of facilities and services, safety and aesthetics, community design and

connectivity and access to public transportation. Strategies targeting this level should precede the individual and social level. This is a key concept in Stokols' model as the environment the individual lives in may promote or deter health outcomes.

The final level is the policy or society level. This level consists of laws, legislation, and policies at a national, provincial, or local level that influence behaviour. For example, policies such as community plans, transportation, education, health, environment and workplace policies are often considered at this level.

Figure 2

The Social Ecological Model



Note. Adapted from "Translating Social Ecological Theory into Guidelines for Community Health Promotion," by D. Stokols, 1996, American Journal of Health Promotion: AJHP, 10(4), p. 282–298.

Core Assumptions of the Social Ecological Model

In addition to the four levels proposed by Stokols (1996), the social ecological model consists of four assumptions. The first assumption is based on the premise that multiple levels of factors influence behaviour. Therefore, to successfully implement interventions, the interrelationship between levels of the social ecological model must be targeted. This is a key aspect of the social ecological model versus theories that target only one or two levels.

The second assumption of the social ecological model is that interactions occur at various levels of organization such as individual, group, organisational, community or population levels, and among various interacting factors within each level. As interactions are multi-dimensional and complex, dynamic interrelationships between individuals and their environment are regarded as a reciprocal relationship. The individual is influenced by the social, physical and policy environments, while at the same time individual, group, or organisations affect the environment. The challenge becomes identifying which factors are key to change at each level.

The third assumption infers that multi-level interventions are most effective in fostering behaviour change, rather than solely focussing on the individual. Changing the environment can result in a modification of behaviour; however, individual and social levels must also be included to foster change.

The fourth assumption implies that social ecological models need to be tailored to each specific behaviour change, as environment and policy variables are often behaviour-specific. The core principles of the social ecological model are particularly important for rural communities where access to resources are limited and cooperation among community partners becomes imperative for successful intervention.

Social Ecological Model Applied in Rural Practice with Older Adults

With the emergence of social ecological models through the work of Bronfenbrenner (1999), McLeroy et al., (1988), and Stokols (1996), greater recognition of the complex interaction among a number of determinants within the individual, social, environmental

and policy domains have been emphasized. The ability for people to engage in health promoting behaviours are influenced by multiple factors within individual, social, environmental, and policy levels (Hill & Hymus, 2019; Nemoto et al., 2021). This is particularly evident in rural communities where people face unique challenges such as lower income, inadequate housing and public transportation, poor access to health care services including specialty services and preventative care, higher functional disability, chronic disability and increased sedentary lifestyle (Bacsu et al., 2014). As a result of changing economic and political forces, rural communities are experiencing more hospital closures, increased financial barriers where lower income makes travel for services difficult, and an out-migration of younger rural residents to urban centres for employment (Malone, 2011; Schmidt et al., 2016). Older adults living in rural communities are often more removed from social supports and services than urban residents (Kaye, 2017). Therefore, to support successful aging among rural older adults, it is imperative to consider the range of factors within each level for effective policy and social work practice.

Individual/Micro Level

The individual or intrapersonal level is at the centre of the social ecological model. It pertains to an individual's physical and cognitive characteristics and past experiences. This level of the social ecological model is strongly influenced by all other levels.

Individual factors include physical characteristics such as sex, age, genetics, health history, education, economic status, along with cognitive characteristics such as knowledge, skills, attitudes and beliefs about factors related to health and healthy behaviors. People's knowledge, skills, attitudes and beliefs help them understand how susceptible they are, how serious a health-related issue is, and the overall threat to them personally; while having knowledge alone is often not enough to change behaviour, it may influence attitudes and decisions that an individual is able to make.

When considering factors within the individual level, rural residents are more likely to experience higher rates of smoking, obesity, and hypertension, as well as lower rates of physical activity and fruit and vegetable consumption (Blackford et al., 2016). These factors have a direct impact on the health of the individual. Thus, compared to their urban counterparts, rural older adults generally experience poorer health in terms of increased mortality, lower life expectancy and functional health, and increased risk of diseases, illness, and injury (Jeffery et al., 2014). Many are also at a higher risk of dying prematurely from circulatory diseases, with rural males having the shortest life expectancy and smaller proportion of their life in good health, when compared to urban males.

Among rural older adults, health is perceived as very important (Bacsu et al., 2014). Many older adults who engage in behaviours, such as regular physical activity and a balanced diet, are aware of and acknowledge positive health benefits to changing their behaviours, particularly in environments that do not support healthy living. Addressing risk factors at the individual level alone has a tendency to put the responsibility on the individual to take control of their health; however, the social ecological model asserts that many other factors outside the individual have a strong influence on health and health-related behaviours; therefore, the individual as part of their social and physical environment also needs to be considered for effective intervention. This approach is supported by Meisner et al. (2019), who stated that among rural older adults, programs and services should strive to promote physical and mental health, in addition to social participation and meaningful connection to others.

Some specific social work strategies that target the individual may include counselling and consultation, life skills training, healthy relationship building, and educational and awareness programs. When designing public health interventions, individual level factors are important to consider, as many individual characteristics such as economic status, for instance, influence an individual's ability to access various services.

Social/Mezzo Level

At a social level, healthy aging is influenced by the opportunity for older adults to participate in social interactions with others (Carver et al., 2018). The social or interpersonal level includes the relationships and social networks an individual takes part in. Factors at this level include families, friends and cultural traditions. These factors have great potential to impact individual behaviors. Rural older adults often report a strong sense of trust and belonging to the community where mutual support is key to healthy aging (Bacsu et al., 2014; Witcher, 2017); therefore, the social environment has an important role in the health of an individual (Stokols, 1996). Social interaction is associated with physical and mental health benefits among older adults, and enhancing opportunities for interaction is a valuable asset in maintaining health and wellness, particularly among older adults in rural communities (Douglas et al., 2017).

Although rural older adults acknowledge that the social interaction while participating in activities with other people is beneficial, many are at increased risk of social isolation and lower social functioning, which is further hindered by the fear of falling and lack

of opportunity to interact socially with others in their community (Bacsu et al., 2014; Schmidt et al., 2021). Social workers can initiate programs and interventions that integrate a social component in order to foster increased participation and engagement in health promoting behaviours among rural older adults. For example, physical activity and social interaction generally share a reciprocal relationship in supporting positive health outcomes among older adults. Massie et al. (2021) report that physical activity programs that encourage social connections within the community and a sense of belonging may be more effective in increasing physical activity levels among older adults. Social support is key in physical activity engagement among rural older adults, particularly when a supportive partner is involved; therefore, engaging people in physical and social activities at the community level may help to improve health outcomes among rural older adults (Soto et al., 2019). Hoogland et al. (2019) further add that older adults benefit from engaging in health-promoting activities with younger relatives as a means of social connectedness and mutual health benefits. As such, intergenerational initiatives such as school and senior visiting programs and activities may further support physical and social health. Hebblethwaite et al. (2020), who studied the experiences of family leisure among intergenerational rural families, found that family-based leisure activities played an important role in developing close social bonds. Berg-Weger and Morley (2020) emphasize the importance of social interaction for all ages, especially during the COVID-19 pandemic, where the social environment was greatly impacted by physical distancing protocols. To promote social interaction, Berg-Weger and Morley suggest interventions such as daily telephone calls and virtual visits.

Although research findings support the use of technology to keep rural older adults socially connected (Hajek & König, 2020; Xie et al., 2020), individual level factors need to be considered; according to Padala et al. (2020), older adults in rural areas report less capability and willingness to participate in video telehealth visits. This resistance to telehealth is further reported by Henning-Smith (2020), who report that older adults use technology at lower rates than younger people and often lack access to reliable internet and computer-based devices. With many organizations and services shifting online, this change may pose a serious barrier for rural older adults to connect and communicate with others. Walker et al. (2021) suggest that among rural older adults, particularly those age 85 and older where infrastructure is limited, a telephone call appears to be an effective means of social communication, particularly during the COVID-19 pandemic where in-person restrictions were in place.

Creative solutions are needed to promote and support social interaction among older adults in rural communities, beginning with understanding the specific facilitators of and barriers to social interaction. There are numerous health-related advantages to living in rural communities that are typically characterized by the opportunities for older adults to socially engage with the community through volunteering at local events and organizations, engaging with others in church groups, community centres, and service clubs (Kaye, 2017).

Gaining a better understanding of healthy aging in rural communities requires further exploration into interventions that support aging and create supportive physical and social environments, particularly in rural areas (WHO, 2011). In order to do so, it is essential to build collaborative partnerships between older adults and community decision-makers, healthcare professionals, policy-makers, and municipal leaders to address barriers to supporting healthy behaviours. Collaborations involving healthcare leaders, community and educational administrators, in consultation with older adults and youth in the community, would be beneficial in developing targeted initiatives to combat social isolation or loneliness.

In addition, an environmental scan of opportunities and challenges that rural communities face in terms of internet, technology and, access to equipment needs further investigating. Levasseur et al. (2020) add that personal and environmental factors all need to be considered to promote social interaction among rural older adults.

Environment/Macro Level

The physical environment has an important influence on health and mental health and wellness (Sallis et al., 2008). In the social ecological model, the physical environment is situated within the organization or at the community level. It includes both the natural and built environment. There are notable differences in healthy aging depending on the context in which people live. According to Jeffery et al. (2014), people living in rural communities face unique opportunities and challenges compared to their urban counterparts. Within many rural communities, access to recreation facilities, parks and trails, aesthetics, and safety influence health of the residents (Schmidt et al., 2021). Living in close proximity to services and recreational facilities are important factors in performing daily activities and initiating social interactions with members of the community (Levasseur et al., 2020).

In many rural and remote communities, social, economic and environmental barriers are evident. These include limited funding for infrastructure, lack of technological advances, and aging and reduced rural populations (CPRA, 2015). Barriers in the physical

environment influence the opportunity and ability for older adults to engage in both physical and social activity. Other challenges common among older adults in rural communities include lack of public transportation, inadequate access to specialized health care services, limited housing and home-care and economic barriers related to lower income.

Although many rural communities are often at a disadvantage in terms of a decreasing and aging population, limited funding for infrastructure, and challenges in accessible technology and transportation, rural living has notable advantages. These include opportunities to connect with the natural environment and having a strong sense of community belonging. Ensuring that communities are walkable and accessible for older adults may encourage more people to engage in active transportation to conduct errands such as getting the mail and paying bills, adding meaningful activity into daily living.

Initiatives such as creating safe, outdoor walking programs or peer-led exercise classes using the natural environment to engage older adults in physical activity are beneficial. Supporting these initiatives requires working collaboratively across various sectors including municipal leadership, health and social organizations, and community organizations that represent the residents. Social workers can play an important role in facilitating and building these collaborations at the community level.

Strategies at this level are often developed to address the social and physical environment simultaneously. For example, communities can improve health by reducing social isolation, improving economic and housing opportunities, and addressing barriers and facilitators of engagement in the natural and built environment. This may include improving the physical and social environment to create safe places where people live, learn, work, and play by addressing the conditions that impact communities such as poverty, safety, isolation, or access to services. Other examples may include increasing access to fresh fruits and vegetables in local stores, creating farmers' markets to promote locally grown, affordable foods, or creating accessible walking trails, parks, or access to indoor sites where older adults can be physically active and engaged with others.

Policy/Macro Level

Supporting social policies and advocating for opportunities for rural older adults to remain active and engaged in the community is very important to health and wellness (Novek et al., 2013). Policy level interventions rely on multi-level influences to address health of the population, recognizing that both policy and environment (social and physical) influence individual behaviour. Recently, organizations have demonstrated the use of the social ecological model in frameworks and guidelines for increasing activity, promoting the use of parks and recreation, and proposing interventions to improve health of populations. An example is the Framework for Recreation in Canada, which is an initiative of the Interprovincial Sport and Recreation Council and the Canadian Parks and Recreation Association (CPRA, 2015). This framework was developed in collaboration between community leaders, local and provincial organizations and national associations to assist communities and partners to create more supportive physical and social environments that encourage recreation and outdoor activity among Canadians. Interventions at each level—individual, social, environmental and policy—are outlined in the recommendations for action.

Other examples of policy level interventions that impact older adults in rural communities include zoning codes and bylaws that support active transportation and public access to existing facilities for programs and service delivery. Partnerships among sectors such as education, religious institutions and community organizations are key in advocating for investments in public housing, infrastructure, and transportation to support older adults in rural communities.

There is much to be gained by using a social ecological model to influence behaviour and implement interventions specific to the needs of rural older adults. By engaging multiple sectors in the planning and decision-making, social workers recognize that interventions that consider multiple levels are typically are more successful than those targeting only one or two levels of influence.

Conclusion

Using a social ecological model produces valuable insight into the relationship between individual, social, and environment factors that influence successful aging among rural older adults. There is much to be gained in focusing on the advantages of rural living, including the connection to the natural environment and the inter-relationship between physical activity and social interaction, and working collaboratively with rural community members and organizations to address the existing barriers that many rural communities are facing. Generalist social workers have the professional training and commitment to understand the importance of addressing the issues faced by rural older adults from a social ecological perspective—a perspective which highlights the importance of considering all aspects of an individual's environment.

Bonnie Jeffery: I am a 3rd generation settler of Irish and Norwegian heritage raised in a small rural community. As a researcher, I recognize my privilege in being able to access certain resources and strive to be aware of my own biases and recognize how they may shape my research and professional practice.

Laurie Schmidt: Identifying as a Caucasian, cis-gender, able-bodied female, I am an English-speaking, middle-class, first-generation university graduate residing in a small urban community. My understanding of rural disparities stems mainly from my role as a healthcare professional and through my educational research, engaging directly with individuals with lived experience. Acknowledging the advantages associated with my societal position, I am mindful of the importance of reflecting on my privilege and biases, recognizing the potential influence on my viewpoint and decisions I make.

Activities and Assignments

- Note your own assumptions and pre-judgments about older adults and aging people in our society and how these relate to the concept of ageism discussed in the chapter. What do you identify as challenges and opportunities for a rural social worker working with this population?
- Vivian is 75 years old and living in a small rural community. She is unable to drive and now lives alone since her husband has moved into a long-term care facility in another community that is 150 km away from where Vivian lives. Vivian's children do not live close by and she has expressed to the social worker that she often feels very lonely and wishes that she had some activities that she could attend as she is very social and likes to visit with other people. Discuss how components of the social ecological model could guide the social worker to suggest some interventions that might assist Vivian.
- Select a rural community in the area where you live and conduct some research to determine the number of older adults, the resources and services available to them, and any gaps that are evident to support successful aging for older adults in that community.

Additional Resources

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PART I: FOUNDATIONS OF RURAL AND NORTHERN SOCIAL WORK PRACTICE

I

The first section of this textbook includes three distinct chapters, all of which focus on the importance of *context* in rural and northern social work practice. One of the important principles of anti-oppressive practice is reflexivity. Through a process of reflexivity, social workers consider the impact of their own values and cultural worldviews while recognizing and respecting the values, culture, and worldviews of the rural and northern communities within which they live and practice. This context informs and guides service and support delivery as well as program and policy development.

In the first chapter, the authors focus on defining the concepts of *rural*, *remote*, and *northern*, and discuss the importance of place-based social work. Chapter 2 builds further on the concept of place with a specific emphasis on anti-oppressive practice. Finally, in chapter 3, the authors weave together three first person narratives to demonstrate the role of social location and context in a very personal way.

While all social workers practice from a foundation of generalist social work skills and knowledge, practice in rural and remote settings – at the micro, mezzo, and macro levels – requires a keen awareness of context, social location, and the impacts of personal, cultural, and community history.

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PART II: PRACTICE APPROACHES AND COMPETENCIES

II

The second section of this textbook builds on the foundations explored in the first section through ideas and concepts shared in four chapters. Each of these chapters further identifies practice competencies required in rural and northern social work practice, and highlights particular approaches that are effective in such settings.

Chapters 4 and 7 bookend the discussions in this section with an exploration of wellness from a trauma-informed perspective. In chapter 4 the authors explore the potential impacts of isolation and secondary trauma, and identify competencies that social workers should develop in order to protect their own wellness, as well as the wellness of clients and communities. Chapter 7 defines the concepts of *burnout*, *vicarious trauma*, and *compassion fatigue*, and examines the approaches that social workers can employ in order to promote mental wellness and build resilience. Chapter 5 explores an intersectional and trauma-informed approach to anti-oppressive practice by focusing on relationships and relationality. Finally, chapter 6 delves deeper into social work competencies that are required and relevant to ensure that care provided by social workers is trauma- and violence-informed.

Each of the chapters in this section further connects back to the concepts of reflexivity, and the importance of recognizing and understanding contexts that were explored in the first three chapters.

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PART III: SELECTED PRACTICE AREAS

III

The third and final section of this textbook examines select practice areas in rural and remote social work settings. By framing discussions at the micro, mezzo, and macro levels, the chapter authors explore practice with individuals who have experienced abuse and intimate partner violence, with older adults, and with newcomer populations. Social work practice in child protection, as well as in the area of mental health and addictions, is also explored.

Each of the chapters in this section defines populations served, highlights context relevant to each of these populations, identifies particular challenges that may arise specific to rural and northern settings, and highlights opportunities for growth and development of social workers.

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Place in Anti-Oppressive Practice: Rurality, Decolonization, and Equity

2

Michelle Lam and Denise Humphreys

What does it mean to practice social work with rural service-users from an anti-oppressive perspective? We are settler women living in the Canadian prairies who share our perspectives and insights on oppressive practice and equity issues in rural human service contexts. Using the method of duo-ethnography, “a collaborative research methodology in which two or more researchers of difference juxtapose their life histories to provide multiple understanding of the world” (Sawyer & Norris, 2012, p. 9), we draw on personal narratives as in education and social work settings. Recurring themes of displacement, colonialism, accessibility, ethics, and stigmatization reveal themselves through our reflections.

I (Denise) have experienced rural social work as an outsider living in an urban setting. My main practice was working with youth, where many youth have been unjustly displaced from their rural communities through the child welfare system. Other areas of my past practice also relate to rurality through other people displaced from rural areas and I have also travelled to provide services periodically in rural areas. I (Michelle) was an English as an Additional Language educator for newcomers living in non-metropolitan areas. As an educator, I witnessed the assimilative forces involved in “welcoming” newcomers to rural Canada. Together, we describe and further explore equity issues associated with education and social services provided to people living in rural areas from our distinct professional backgrounds. It is important to note that both Denise and Michelle identify as white women, which shapes our experiences and understandings, leaving experiences of Black, Indigenous, and racialized[1] social workers, and/or adherents of religions not widely represented in rural and northern communities in Canada outside the scope of what we can speak to in our discussions. Our experiences suggest that change in provision of services is needed to address the oppression and inequity rural residents may encounter through dominant human service practices. After recognizing these issues, we suggest further action is needed towards achieving anti-oppressive practice and more equitable futures for rural residents.

Learning Objectives

By the end of this chapter you will have had the opportunity to:

- Learn about the application of anti-oppressive practice in rural settings
- Learn about using reflexivity when working with rural communities
- Learn how to use practice frameworks that may be helpful when working with rural service-users
- Learn about the application of the Canadian Association of Social Workers (CASW) Code of Ethics, Values, and Guiding Principles in context with anti-oppressive practice

Rurality and the Importance of Place

Rural contexts within the western Canadian provinces are a significant portion of the population, although the term “rural” is contested. Rural can mean “non-urban,” or it can be used to denote a specific community or region. In addition, some cities can be described as “rurally influenced cities,” which means that although they technically classify as cities according to population numbers, they retain strong connections to rural industries and identities (Banack, 2018). One example of a rurally-influenced city is be Brandon, Manitoba. While it is technically a city, it is sustained in large part by the surrounding agricultural communities. This is notable in both the city’s moniker, “The Wheat City,” and the city’s hockey team, “The Wheat Kings.” It’s also observable in the ways rurality influences social relationships (Lam, 2021). Others define rural according to economic and social attributes like extensive land use, attachment to the environment, and cohesive social structures (Blake & Nurse, 2003). According to Statistics Canada, rural communities have less than ten thousand inhabitants (Statistics Canada, 2001). Depending on how rural is defined, Canada’s rural population varies between 22 percent and 38 percent (Statistics Canada, 2001). In the words of columnist Jeffrey Simpson (2018), Canada is a “country of cities strung together by countryside” (p. 2). Economically, rural areas produce 30 percent of Canada’s GDP (Keung, 2019), supplying food, energy, and other supports to the rest of the country. This production is intertwined with the social attributes of these areas, including the manifestation of colonial logics through anti-Indigenous resource exploitation, agri-industrial and corporate expansion, and neocolonialism (de Finney, 2022). Across these colonial logics, examples of Indigenous resistance such as vitalizing kinship systems across rural and urban spatialities are also demonstrated (de Finney, 2022).

In the social sciences, the significance of place is often overlooked. If mentioned, place is "just the surface upon which life happens" (Tuck & McKenzie, 2015a, p. 9). Yet places are not neutral backdrops. They should not be reduced to bounded physical landscapes or symbols of the past but are mobile and dynamic "sites of presence, futurity, imagination, power, and knowing" (Tuck & McKenzie, 2015a, p. 15) experienced, understood, and practiced differently. Against a backdrop of globalization, neoliberalism, colonialism, climate change, and environmental degradation, Critical Place Inquiry (CPI) draws attention to place, an element often lacking in research in social work. Drawing on postmodern shifts, the shifts in society abandoning universal reason, truth and unitary schemas (Patton, 2001), along with spatial, new materialist, and other critical shifts in social research (Jocson, 2016; Tuck & McKenzie, 2015a) CPI reminds researchers and practitioners of the interconnectivity between humans and nature. It calls to attention the necessity of considering place and land, as well as the ongoing displacement and dispossession of Indigenous Peoples in relation to land (Tuck & McKenzie, 2015b). Centering place requires acknowledgement of colonial histories and lasting impacts. Centering place encompasses the dynamic, interactive mobility of places, mutual shaping of social practices and places, recognition of disparate experiences, understandings, and practices of place, countering place-based processes of colonialism and their further entrenchment through social science research, the consideration of non-human inhabitants and the land itself, a relational ethic of accountability, and valuing the contributions of Indigenous epistemologies (Tuck & McKenzie, 2015b).

Place can encompass land, nature, the non-human world, and community. Yet within discussions of place, definitions are contested. Yet only idealizing place as a stable, warm, intimate community can erase distinctions among "historical, geographical, cultural, political, economic, and other dimensions of place construction, [as well as] issues of strategy, power, cooperation, and exploitation" (Nespor, 2008, p. 478). Nespor (2008) argues for a robust definition that neither considers the transition from a rural to industrial society as a fall, nor find its salvation in a localized, moralized emphasis. Rather, definitions of place are needed which recognize continual interaction with the "outside," and acknowledge power, class, gender, and racial dynamics within local places and broader structures. Jocson (2016) also emphasizes this notion. She defines place as "lived space with dynamic networks, shaped by and constituting cultures and identities" (Jocson, 2016, p. 1269). Defining place is thus a difficult task, as it can be used to denote something as simple as a geographical location with a bounded setting or as complex as a dynamic and changing accomplishment created by permeable borders through which relationships and transactions occur and are shaped by values and meanings (Jocson, 2016; Nespor, 2008). Place carries a constellation of networks, connections to other places, shifting negotiations, and social realities (Jocson, 2016). With this understanding of place, it is important to nuance ideas of rurality and rural identity. To provide an example, although Michelle often describes herself as being from a rural community, it is important to point out that within this geographical location, her positioning as a white woman from a relatively wealthy family within that geography informed her interactions.

Some place-based initiatives tend to reorient activity to a local scale to reverse trends of neoliberalism, globalization, or climate change. These initiatives encounter problematic practical barriers. It is not possible to ignore these realities and focus only on local places. A focus on larger systemic factors is also needed, as well as an examination of how these forces impact localities. For example, a teacher works within a system that includes standardized testing. A local business competes with big box stores. Gatherers, hunters, trappers, and farmers engage with land that large-scale industries often impact. As these examples illustrate, not only is the paradigm of place-consciousness important to consider, the realities of the places themselves and the connections they have to other systems are also important. As Nespor (2008) writes, "The question, then, is not whether or not we are place-conscious, it is the places of which we are conscious" (p. 487).

To this end, humans are inseparable from nature (Tuck & McKenzie, 2015a). Rooted in decolonizing research, environmental research, and Indigenous methodologies, CPI aims to deepen understandings of place, redefining it beyond geographical and physical space. It seeks to remind "how places and our orientations to them are informed by, and determinants of, history, empire, and culture" (Tuck & McKenzie, 2015a, p. 23). In other words, people do not only "construct place but that, in fact, the very matter and material of place profoundly acts on and affects place-making" (Jocson, 2016, p. 1272).

CPI employs a range of research methodologies, data collection, and analysis methods, but in each, place is conceptually engaged explicitly and politically (Tuck & McKenzie, 2015a). Within CPI, legitimacy is established through relational validity (Tuck & McKenzie, 2015b), which can be described as responsibility and accountability toward the relationality of life, dependent on other species, land, social context, and future generations (Tuck & McKenzie, 2015b). This chapter begins by acknowledging that rural, remote, and northern communities are not one single context but uniquely shaped by the land, history, culture, and the complex web of relationships, always dynamic and shifting. For example, in rural areas, communities separated by only a few kilometres

may experience rivalry and prejudice between towns, racial groups, or between settler and Indigenous communities (Epp & Whitson, 2001; Perry, 2018). While this chapter calls for imagination in pursuit of equity, the pathway towards that goal will look different in different contexts because of the importance of place.

Stories that Beget Stories

To explore these ideas further, we employed a methodology known as duo-ethnography (Sawyer & Norris, 2012), by which two people use their own life stories and reflections to prompt further thoughts in one another. In this relational way, "stories beget stories" (Sawyer & Norris, 2012, p. 28), leading to new ways of thinking about the topic for both participants.

In any duo-ethnography, the two participants must recognize their positioning and be dissimilar in order to spark further insights in one another. They must also enter the process with humility, acknowledging that their own stories and insights will be challenged and reinterpreted through the process. This chapter focuses on social work, reflexivity, and rurality. Our backgrounds meant that we could bring insights from distinct professions and relationships with rural places, which led to valuable insights for social work.

To do this, we spent several months "conversing" through a shared document. We began with the question, "Why have you gravitated towards 'helping professions?"' and then began sharing our stories with each other. In the end, we had 21 pages of reflections on early experiences, deconstructions, ethical practice, education, values, race, relationships, community, rural places, and current beliefs. We then took this document and began examining it for areas where our stories held similarities and other themes that demonstrated insights into social work practice in rural communities.

There are plenty of benefits in working across disciplines, such as breaking down the silos or echo chambers that each field tends to create. Because of our (Denise and Michelle's) unique backgrounds, we were forced to avoid the jargon of our respective fields, which caused us both to think about the topic in new ways. If you ever want to challenge yourself in a similar way, try explaining what you do without using any discipline-specific vocabulary. It may be more challenging than you think!

Positionality

I (Michelle) approach this chapter as a white woman from a rural community. Both whiteness and rurality have shaped me, my beliefs and perceptions of reality, and the position I take up in society. I was drawn to the explanation of privilege by Harry Brod in 1989:

> We need to be clear that there is no such thing as giving up one's privilege to be 'outside' the system. One is always in the system. The only question is whether one is part of the system in a way that challenges or strengthens the status quo. Privilege is not something I take and which therefore have the option of not taking. It is something that society gives me, and unless I change the institutions which give it to me, they will continue to give it, and I will continue to have it, however noble and equalitarian my intentions. (p. 280)

This passage describes my positionality concerning systemic injustice based on identity. I worked for 10 years as an English as an Additional Language (EAL) teacher. In that role, I heard stories of discrimination and racism from my students and have observed that those who strategically adopted the traits of the dominant culture tended to find success more quickly. This pattern disturbed me, yet coincides with research on how "playing the game" (Henry et al., 2017, p. 307) still ultimately led to success for Black, Indigenous, and racialized individuals. I am now the director of Brandon University's Centre for Applied Research and Education in Indigenous, Rural, and Remote Settings (CARES). In this role, I continue to see themes of discrimination, racism, marginalization, and othering. However, I also see strength, resilience, and hope. As an anti-racist scholar on a journey of decolonizing myself and the systems of which I am part, it feels confusing to be working towards my loss of status, privilege, and prestige. However, in the words of Debby Irving, "It's not enough to feel empathy toward people on the downside; white people must also see themselves on the upside to understand that discrimination results from privilege." (2014, p. 73).

I (Denise) am also a white woman but from an urban community. I live with racial privilege and the privilege that comes from living in an urban setting. bell hooks (2014) helps describe my social position eloquently:

> The process begins with the individual woman's acceptance that American women, without exception, are socialized to be racist, classist and sexist, in varying degrees, and that labelling ourselves feminists does not change the fact that we must

consciously work to rid ourselves of the legacy of negative socialization. (p. 157)

I may experience particular forms of oppression in my own life because of my social location, but this fact does not absolve me from the impact of other positionalities. I am a colonizer and racist based on my negative socialization. The hooks passage above resonates with how Michelle and I must consciously work to rid ourselves of our racism. The geography of where we live has also affected how we experience white privilege. I, especially as an urban resident, have learned racist perspectives from living in the metropolis.

From recent research Michelle and I were a part of, we found participants noted that healthcare facilities, places of business and work, and the street itself were significant places where racism was experienced (Lam et al., 2022; Lam et al., 2023). Many rural residents must travel to urban areas to access healthcare, employment opportunities, and goods and services. Many participants in the study noted they experienced increased racism when coming to the city. This study is one example of the racism in urban areas and how I am privileged to have increased access to healthcare, employment opportunities, goods and services, and racial privilege within these areas of social life.

Our positionalities in writing this chapter also go beyond unjust privilege. We also recognize that our positioning in terms of place shapes the responsibilities we have to others. We approach this chapter as white women who have responsibilities to place based on those established by the Indigenous nations of the lands we live on. This is reflected in the chapter as we use reflexivity to better understand some of our responsibilities to others and each other. Michelle lives on Treaty 2 territory and Denise lives on Treaty 6 territory.

Exploring Early Reflections and Formative Experiences

Through the process of duo-ethnography, we found that there were significant similarities in our early experiences. We both entered our careers because we wanted to "help people" and had childhoods that involved volunteer work. These early experiences formed our values. We also both reflected on experiences in the late teenage and early adult years where we began recognizing that there were issues related to power and inequity. I (Michelle) wrote, "I stopped to critically wonder whether the help was always needed or whether I might be perpetuating problematic dynamics," and I (Denise) wrote, "Through an increase in experience, education, maturity and learning, my early ideas of 'helping people' in my childhood and early teen years shifted to recognizing my role in the production and maintenance of inequity in my community."[2]

This desire to help others is not limited to us. Both teachers and social workers tell stories about themselves. As emphasized particularly in white and western cultures many like us entered this profession because we have what Irving calls "Robin Hood Syndrome" (2014, p. 106) or the good feelings that come from helping other people. In current dominant systems in Canada, the stories of teachers and social workers as helpers begin early in life. Children are praised for fixing problems and helping others. These fix-it, help-them messages don't change much as children age. "Wow, you're going to be a teacher! They will be so lucky to have you" or "a social worker, that will be so hard, very noble of you." While encouraging values such as compassion, responsibility, and helpfulness are certainly not wrong, it is necessary to acknowledge and critically engage with the systems that have marginalized others in the first place.

We questioned what compelled us to go through these shifts in our understanding. While we identified many factors, such as gender, spirituality, and the influences of family and community, there were other nuances. For me (Michelle), it involved questioning motivation, "*I started realizing that I cared a lot about what the people in my life thought about me, and being in this 'helping' role was a way I was garnering their affirmation…when I finally dared to look at it, it made me question [my motivation].*" Becoming a healthier individual *("There was a needy person underneath all of it, looking for love, validation, or affirmation")* meant deconstructing the ways I was using my identity as a "helper" to try to make other people like me and think well of me. Through the process of becoming a healthier person, I was able to find the courage to face my positionality and recognize that "*helping was more about me and my insecurities than about the people I was caring for – that was a frightening prospect, and hard to work through.*"

I (Denise) also questioned my positionality and privilege. I recognized that my initial goal of "helping people" was significantly shaped by the centering of my own desire for connection and belonging. Despite this centering being problematic, I found caring relationships in the community that introduced me more practically to social justice. One of my early volunteer experiences, which involved activities with older adults in a care home, caused me to question later why these older adults were feeling lonely and

isolated in the first place. I began questioning the systems that I had experiences with, grappling with my positionality and what it meant to be "*part of separating families, displacing individuals from rural to group homes, half-way houses, and to cities in which parole boards chose that it was fit for past offenders to reintegrate*." I began asking a key critical question, "*Why am I needed?*"

Both of us asked the big "why" questions as early adults, although we phrased them differently. I (Michelle) asked, "*Why am I doing this?*" and examined my motivations. I (Denise) asked, "*Why am I needed?*" and challenged the systems of which I was a part. These "big questions" point to the fact that both reflexivity and critical consciousness are needed in social work. This is reiterated in the literature. Reflexivity is a key tool in addressing power in social relations and is paramount in deconstructing and reconstructing knowledge for emancipatory purposes (Butler et al., 2007; D'Cruz et al., 2007; Houston, 2015; Trevelyan et al., 2014). The use of various forms of reflexivity can improve practice by going beyond procedural accountability by applying critical knowledge to the power relations in context (D'Cruz et al., 2007). This may assist in challenging power and increasing social change (D'Cruz et al., 2007). It may also go further to expand the context of practice of social workers, where historically social workers have tended to focus on symptoms (Midgley, 2014; Midgley & Conley, 2010; & Pawar, 2014b as cited in Pawar, 2019) like poverty and homelessness, rather than root causes of social issues such as the effects of capitalism on people (Gil, 1998 as cited in McMahon et al., 2010).

Deconstructing "Helping" Professions

After the initial and harsh realizations that we both encountered, our stories moved towards deconstructing. I (Denise) reflected on the answers to my earlier question of "*Why am I needed?*" That reflection shifted to "*I am not needed…I don't need to insert myself here, and [especially in my current context] I am contributing to upholding a white system of social work.*" I (Michelle) also had a similar reorientation: "*As a younger person, I felt like I was a good person if other people thought I was 'doing good,' and 'doing good' meant helping others, so it was a kind of simplistic A+B=C equation.*"

However, deconstructing is not a simple once-and-done event. It is an ongoing process, and one which we are still encountering today in various ways. I (Denise) reflected that many careers in Canadian society will be oppressive. Even though education is not immune to this, I chose to further my schooling to become a professor, so I could be a part of harm reduction through contributing to education about colonialism and anti-colonialism. I was reminded of Audre Lorde's quote, "The master's tools will never dismantle the master's house. They may allow us to temporarily beat him at his own game, but they will never enable us to bring about genuine change" (1984, p. 2). At the same time, we also reflected that while we are learning and growing, and reflecting and deconstructing, Black, Indigenous, and racialized people and/or many equity-deserving groups are still experiencing violence. I (Denise) wrote, "*I have tried to make sure I don't get comfortable thinking I have my whole lifetime to learn, because it will be at the expense of the wellbeing of Black, Indigenous, and racialized and equity-deserving individuals.*" This comment prompted me (Michelle) to write that "*Inertia, or 'keeping the status quo,' or 'only moving as fast as the ship can sail,' harms people.*" Change is necessary to provide increasingly equitable and just services. For us, asking critical questions and deconstructing our previously held notions was a significant step towards creating positive change.

Maintaining the status quo, when the status quo is harmful, is a dangerous place to settle. Both of us identified this obstacle as "*inertia*." I (Denise) wrote, "*It takes nothing to be oppressive as a social worker. It's not a matter of doing something oppressive; the system was built to be oppressive, and doing nothing will uphold it.*" Collier, the author of Social Work with Rural Peoples, emphasizes, "It is difficult to change social work practices to pursue different ends. But the choice of serving only the interests of the employer… is nothing more than [serving] a colonial administrator" (2006, p. 49). I (Michelle) shared a story about trying to make change within a highly-bureaucratic system, where a suggestion to rectify an inequitable practice moved through a department meeting, to a faculty meeting, to another faculty meeting, to a discussion with administration, and then was moved into a sub-committee that is still (as of now) talking about the suggestion. I (Michelle) pointed out that the bureaucracy of the system is not only difficult and slow to maneuver and also has a "*huge learning curve*" for many people involved in making decisions. In the meantime, while new hires are learning the system, or while the bureaucratic system itself prevents meaningful change, the status quo continues to cause harm.

Harmful Practices in Rural Places

Our deconstruction and subsequent critical reflections through this duo-ethnography led us to identify ways that dominant social work practice can cause harm specifically in rural places. We want to note that some of these practices are not motivated by hatred or ill intent. However, as Paul Gorski wrote, "Good intentions are not enough" (2008, p.1). Good intentions can still be harmful,

and we must consider the intent and the impact of our actions. That being said, these harmful practices result from violent colonialism that continues to play out, even if they may be more subtle forms of what Durst identifies as "benevolent colonialism" (2010, p. 76). A part of this benevolent colonialism includes the intent to provide services and avenues to success, but violent impacts are still experienced through phenomena such as displacement from rural homes to access services and white values embedded in notions of success.

Displacement

One example of the ways many of those from rural places experience inequity is through displacement. This is particularly relevant in rural places affected by colonialism such as our own place-based context. We have seen this displacement happening in post-secondary institutions though our time spent in them. Because they are primarily located in major cities, and students often are separated from families and communities to attend hundreds of kilometres away. Displacement also occurs when rural residents may be forced to leave their homes due to factors such as socioeconomic reasons or to access social services. As services become more centralized in urban areas, rural communities and the residents within are unequally served.

I (Denise) reflected on the displacement often caused by colonial effects on support systems and the lack of services in rural communities, "*From my experience in social work, there is an aim to be equitable, but in practice, equitable outcomes do not occur.*" I (Denise) cited the example of youth and children leaving their communities, people having to travel for appointments instead of the social workers in their locations or the particular challenges effected by colonialism on the self-governance of rural communities. I (Denise) also pointed out that rurality made it especially difficult for parents and other caregivers in the justice system to see their children, and reiterated, "*Just because there may be fewer people from rural areas should not mean they have inequitable access to their children.*"

Rural places should not experience service inequity due to the nature of their locality. However, rural residents experience social injustice in transportation, healthcare (both physical and mental), education, government and private sector services, and employment (Senate Committee on Agriculture and Forestry, 2006 as cited in Annie & Patterson, 2005). For example, as published in the journal *Canadian Social Work*, rural residents in Canada lack access to palliative care services compared to their urban counterparts (CIHI 2023; Epp, 2012; Pesut et al. 2022; Pugh et al., 2019). The lack of availability of social workers and palliative care teams leaves many residents to navigate end-of-life care and grief without any formal supports. Because many established support systems may also be disrupted through displacement, this gap also creates more disjuncture in the supports of families and communities.

It is also important to understand how these issues are rooted in historical and contemporary processes of colonialism. Canadian social welfare systems have been established through the settler colonial modalities of capitalism and in the current organizational structures created and sustained through the division of labour and industrialized centres. This establishment of social services by settler colonial systems works to continue "service inequity" and displacement. One way how this has manifested is through racial extractivism. Fortier and Wong (2019) describe how social workers have served a purpose within racial extractivism through efforts to delegitimize Indigenous care and impose social work providers to 'help' communities 'adjust' to Canadian extraction and industrial development. These providers have often broken families through displacing children through child protection services and through other forms of violent displacement and fractures of care to attempt to gain easier access Indigenous lands for industry (Fortier & Wong, 2019). Settler colonial manifestations such as these within the social work field are not divorced from service inequity and deeper logics of 'care' within rural contexts.

White Notions of Success

Both social work and education are overwhelmingly white fields. For example, only 13 percent of educators in Canada are visible minorities (Statistics Canada, 2016) compared to 25 percent of the total population. Social work is even more stark. In 2021, it was found that only 18 percent of social workers in Canada were visible minority status and only 7 percent were Indigenous (McNamee et al., 2023). In Winnipeg (Manitoba's largest city), only 5 percent of all social workers in the city are racialized (See-Toh, 2012). Little research is available to the public on the current demographics of social workers in Canada (Hoselton & Walsh, 2023), including racial and ethnic demographics. However, both historically and currently in the literature, it is confirmed that there has been and continues to be a high proportion of white social workers in Canada (Bejan et al., 2014; McNamee et al., 2023) Fourteen percent of healthcare and social assistance workers are racialized individuals, and 86 percent were non-racialized individuals (Statistics Canada, 2006). In 2000, 74 percent of Canadian social workers were employed in healthcare and social service settings

(Stephenson, 2000). Based on these statistics, it appears many sectors in the social work field are white-dominated. In addition to underrepresentation, based on a large-scale literature review of experiences of visible minority social workers, it is clear that despite adopting anti-racist and anti-oppressive practices, the field of social work has not yet removed barriers to mainstream social service agencies (Corley & Young, 2018; Strier & Binyamin, 2014; Yee et al., 2006).

Because the field is so predominately white and despite it being women-dominated, white values including patriarchy permeate the field (Almeida et al., 2019 in BlackDeer & Gandarilla Ocampo, 2022). We reflected on how these values continued to influence social work, with particular attention to rural areas. I (Michelle) reflected on the value of independence and acknowledged that although many communities value interdependence, autonomy or a sense of rugged individualism was still "*pushed as though it's better*." I (Denise) shared examples from reasons for initial contact with child protection services to case planning where the goals determined by the provincial agencies and organizations were generally attributed more value than youth and family/community goals and familial or community ties. I (Denise) also shared my experiences with corrections: "*What warrants contact with the justice system and frameworks for addressing 'deviance' are based on white ideals.*" I (Denise) pointed out the western "tough on crime" agendas of workers, which is primarily punishment-focused instead of focusing on transformative approaches, and I concluded, "*Did it actually help the individual and the public in a lot of cases? No, I don't think so.*" The Canadian approaches to justice often focus on the social control and retribution of individuals rather than community-building and social change. Hyper-individualistic approaches that devalue community and familiar connections are deeply rooted in white colonial values such as meritocracy, that assigns power and worth based on achievement (Young, 1958) and individualism. For me (Michelle), this realization came after living in Asia for five years: "*I realized I have a very western way of thinking about things.*" I (Michelle) used the example of a Vietnamese staff meeting where those with young children were not expected to attend if it was held after school hours. This difference in expectation depending on individual contexts and circumstances was seen as a normal consideration of the variances in the community, and with the understanding that at other times, accommodations would flow in other directions. I (Michelle) wrote, "*I think it's closer to the idea of 'equity' and not just 'equality.'*"

These white ideals or values are often based on deficit models of "the other" and attribute the lack of this arbitrary definition of success to personal factors rather than systems (Delpit, 2006; Park, 2005). Research from the field of education shows that teachers use different interventions and strategies for Black, Indigenous, and racialized students (Glock, 2016), to the point where they have even coined a phrase "pedagogy of poverty" to explain this type of teaching based on a deficit model (Haberman, 2010). The use of the deficit model is commonly used by white people and systems against equity-deserving groups in institutions, communities, workplaces, families, and individuals. This approach is supported by "those who have low expectations for minorities and the poor. People with limited vision frequently see value in limited and limiting forms of pedagogy. They believe that at-risk students are served by a directive, controlling pedagogy" (Haberman, 2010, p. 82). Within social work, the same deficit response can be seen in the Canadian justice system, where those with low expectations believe that a controlling, punitive response is the best way forward. The research, however, suggests otherwise, with transformative, community, and healing approaches to justice as more effective in lowering rates of recidivism (Bonta, 2003; de Beus & Rodriguez, 2007; Fulham, 2018; Hansen, 2019). Moreover, deficit responses are tied to the systemic processes that help create and maintain the conditions for the genocides of Indigenous and Black peoples and their lands through mass incarceration (Reece, 2020). Therefore, when deficit responses are employed in racist and colonial ways, they contribute to genocidal societies.

With colonization and the domination of western ways, fluency with western behaviours, beliefs, mannerisms, and languages have become a barometer for cultural "others" – Black, Indigenous and racialized people – for so-called success; success was not necessarily determined by Black, Indigenous and racialized individuals themselves. When white social workers or teachers and systems define success for their service users or students, they implicitly or explicitly establish whiteness as the de facto standard against which all else is measured (Applebaum, 2012; ; Badwall, 2013; Davis, 2016; Delpit, 2006; Walter & Baltra-Ulloa, 2019; Whitaker, 2019). However, jettisoning cultural expression, beliefs, and worldviews is not what is required for students and service-users to succeed, in the sense of decolonial success. Marom (2018) describes how professionals who have been marginalized had to adopt a particular dress code, management style, and communication style to be considered "'professional." Expectations of western ideas of professionalism are often rooted in oppressions such as racism, ableism, classism, sexism, anti-queerness, ageism, and anti-fatness. The assumption of white western expectations coincides with research on rural immigration and how newcomers adapt to find success. As Lam writes, "One way that newcomers try to overcome these stereotypes and disadvantages is to 'act white'" (2021, pg. 95). However, as Marom (2018) writes, "professionalism is not an objective concept, but rather a manifestation of certain explicit and implicit assumptions grounded in certain worldviews" (p. 7). The recent institutional emphasis on "soft

skills" in education or the manifestations of "interpersonal competencies" in social work could be similarly critiqued for often valuing a western set of cultural norms and expressions over others. For example, effective skills taught in communications courses for social work may involve open communication suggestions of making eye contact or skills such as mirroring. However, only certain cultures, including western cultures, find it polite to make eye contact when conversing. It may be considered disrespectful in certain cultures and contexts (City of Saskatoon, 2019). Where it is white social workers working with a Black, Indigenous and racialized service-users or workers, mirroring may be a professional asset in offering a chance to remove some communication barriers, but it also may be seen as mocking or culturally appropriative if not practiced wisely. Conversely, how mirroring is taught in dominant forms of education does not necessarily consider the possibility of Black, Indigenous, and racialized social workers being encouraged to assimilate or also appropriate if they do not share the same culture as those they are working alongside. When cultural sensitivity and rapport building is taught this way, the assumption is that social workers will be white, that service-users will not be, and that overlooks injurious outcomes.

In addition to telling stories about themselves, social workers and teachers also tell stories about their students and service-users. For example, in white-dominated systems, Indigenous students are often spoken of as a "problem," an "issue," or a "challenge" (Applebaum, 2012; Collins, 2012; Delpit, 2006). These helping professions have been socialized to see Black, Indigenous, and racialized service-users and students as needier and deficient in comparison to white service-users and students (Applebaum, 2012; Delpit, 2006; Glock, 2016). I (Denise) have experienced hearing people who are Black, Indigenous, and racialized being labelled as "at-risk" or "vulnerable" populations in social work settings. I (Michelle) have heard inner-city schools, where percentages of diverse populations are higher, labeled in similar ways. These social work and teaching settings typically do not focus on the strengths that Black, Indigenous and racialized individuals and groups bring to the community or the learning opportunities that all community members can have (Collins, 2012; Delpit, 2006; Glock, 2016). Instead, these institutional settings focus on an imagined route to success within colonial systems, which involves adopting white patterns of behaviour, language, and being.

Whether in Canadian social work or education, the helper's role is constructed to involve understanding the individuals' deficiencies and then fault finding as to the cause of those shortcomings (Amadasun & Omorogiuwa, 2020; Applebaum, 2012; Baskin & Sinclair, 2015; Gorski, 2008; Henwood et al., 2015; Weick et al., 1989). When the deficiencies have been identified, then social workers and teachers are taught to investigate what is causing these deficiencies, which usually blames individual students or service-users for not achieving the established norms (Amadasun & Omorogiuwa, 2020; Applebaum, 2012; Baskin & Sinclair, 2015; Delpit, 2006; Glock, 2016; Henwood et al., 2015; Weick et al., 1989; Whitaker, 2019). Thus, when any student or service-user is not living up to the established "white" norms, then it is taught that it is up to the "helper" to "fix" those who are not "acting white". The idea of fixing is commonly equated with assimilating into the same oppressive culture (Gorski, 2008).

We reflected on this tendency through our duo-ethnography and found that these white values are tied to social rewards. One example included the values of rural settler communities that are tied to "fitting in." I (Michelle) pointed out that although rural values such as community and dedication are not unique to white people and that there are also rural people who don't hold those values, specific "performances" tend to lead to acceptance in small communities. I (Michelle) wrote, "*If a newcomer family moved in and pitched in to help [with local sports or community events], they'd probably be welcomed with open arms and casseroles. But if they preferred to keep to themselves, people might not be as welcoming.*" This example demonstrated that in rural places, certain behaviours influence a sense of belonging. For example, belonging has been linked with supporting local community initiatives and events and demonstrating social participation (Adedokun, 2009; Carver, et al., 2019). I (Denise) pointed out a similar link between values and certain rewards, such as employers and employees being rewarded for managing high caseloads on low budgets.

In the CASW Code of Ethics, Values and Guiding Principles, "Social workers promote the self-determination and autonomy of all people" (2024, p.5). However, in practice, as we have described above, the ideas about what constitutes successes are often externally applied and based on white values. What would it look like to work towards service users' definitions of success? In response to this question, Brandon University CARES Research Centre shared the outcome of a photovoice research project that asked Indigenous youth leaders from around the province to use photos and stories to share their perspectives about success, leadership, and Indigenous cultures (2016). These stories highlight the need to critically reflect on assumptions about goals, identity, and power and challenged the white-centric notions of success typically held by teachers and social workers.

Rural Relationships

Rural communities can be tightly knit places, which can lead to complexity within professional boundaries. We both found these complexities challenging to navigate. As a residential caseworker in child welfare, I (Denise) was a caregiver for youth. Still, I had

to be strict that the time I spent with youth was in set work hours and most forms of personal touch were discouraged, which led to feelings of inauthenticity in the relationship at times. However, the complexity arose because a more authentic approach could lead to a blurring of roles, potential burnout and inappropriate relationships for those who might abuse professional freedoms. Social workers must navigate this complexity while upholding CASW guiding principle 5.2 maintaining appropriate professional boundaries with service-users (CASW, 2024). I (Denise) wrote, "*This takes quite a bit of navigating on the professional's part on how to balance relationality with professionalism.*" I (Michelle) wholeheartedly agreed with this complexity.

I (Michelle) pointed out that in rural areas, "*students know where their teacher lives, know all their family members and run into each other doing errands around town.*" I also pointed out that there are positives and negatives of such interconnectivity. The positives are that there are many opportunities for collecting feedback and developing relationships that are more holistic instead of one-dimensional; however, there can also be difficulties with the dual relationships that we described. I (Michelle) wrote, "*You're never not a teacher in a small town.*" As an additional layer, I shared my struggles with the differences in cultural expectations around personal/professional boundaries while living in Asia, where it was normal and expected for students to regularly "pop in" to visit their teachers at home. I (Michelle) wrote, "*Students felt comfortable, but it went against my western ideas of separating personal and professional. I wanted to be culturally sensitive, but it's something I struggled with. I always felt some tension, even though I hope they [the students] didn't know it!*" The same struggles can be seen in the realm of social media and the decisions that individuals make about whether to allow their students or service-users to follow their accounts. For some, the personal approach builds connections and strengthens relationships. For others, constant accessibility can lead to fatigue and burnout (Lam & Kirk, 2020). I (Michelle) wrote, "*I don't think there's one clear way.*" These decisions are dependent on policy, personal approaches, and context. As the CASW Code of Ethics, Values, and Guiding Principles suggests, "social workers [are to] seek supervision and consultation about the potential blurring of professional and personal boundaries" and are to "take steps to mitigate conflicts where close personal relationships with service users or with colleagues already exist" (2024, p. 17).

Levels of Social Work

Throughout our stories, we were able to engage in anti-oppressive practice through varying levels of social work. Inevitably, we always are engaged with each level, but we also highlighted times we engaged with rural service-users in each one. Both of us related our positionalities to each level of social work. We reflected on our locations within the social structures (macro) of our practice working with individual service-users and families (micro) and relevant communities and organizations (mezzo).

The same can be said of the white values we examined in our places of work. For example, I (Michelle) shared the interconnection of language and culture:

> *Travel[ing] to several different countries thinking that I was doing a good thing teaching English…[It] was so laced with my own culture that it was hard to separate language teaching from cultural imposition. Language and culture are very strongly intertwined.*

We both noted that language and pedagogy are both influenced by micro, mezzo, and macro levels. For example, drawing from our involvement in post-secondary institutions, we have seen how language exists nominally in education, but the discourse itself, the pedagogies by which it is taught, and the social context where it is taught are affected by community and systemic levels.

When referencing the social work approaches that have helped guide my (Denise) practice towards being more anti-oppressive, it must be noted they are impacted by each level described above. I typically "*operate my practice from person-in-environment and strengths-based approaches to practice [and] I think using these theories have helped support this idea of social workers not breaking up preexisting ties individuals may have.*" Here I am speaking to the strengths of individuals and communities, including their relationships. These strengths are in context with the greater systems around them and align with the definitions of place described at the beginning of the chapter.

Both of us recognized the complexity of how the place of practice relates to each level of social work. Place, remember, means more than just geography. It involves power imbalances, histories, cultures, politics, economics, and interactions at multiple levels. Working together in a university, we agreed with this statement from our conversation: "*Post-secondary institutions are still colonial entities. And from a rural perspective, they again separate families and communities by forcibly displacing students to urban centres.*" In this example, we see that universities are institutions at the mezzo level, with the whole education system being at the macro level. Students and families separated take place on the micro level, and the separation of communities at the mezzo

level. No place of practice exists exclusively at one level. There may be a focus on one in specific settings, but we found they are always interrelated. Therefore, we found reflexivity essential to shift our orientation to all levels by having each of them on our radar. We found looking at each level was helpful for us in better understanding how whiteness operates in social work. The interconnection of relationships in social work is not only present in the framework of levels. This discussion of levels also brings us back to the relationality described earlier in this chapter by Tuck and McKenzie (2015b) when discussing critical place inquiry. The responsibility and accountability toward the relationality of life they describe could include sustaining each relationship we have that are interrelated with many others, such as co-workers, service-users, communities, nations, and the land, both before and after us.

Things We Learned About Ourselves

Doing this process with Denise has helped me (Michelle) critically analyze my assumptions and realize that there are many places where social work and education are grappling with the same issues. The themes of this chapter – rurality, decolonization, equity, deconstruction, anti-oppressive practice – are themes that both of us grapple with in our spheres of influence. These also inform our ideas about future directions for social work practice. It has been eye-opening and encouraging to see that these issues are being addressed in multiple, overlapping fields such as social work and education.

I (Denise) have realized that duo-ethnography is a research methodology I wish I had known of sooner. I am very thankful Michelle introduced it to me. I find this way of knowing and learning can challenge colonial defaults within our professions and scholarship. For example, this duo-ethnography helped make knowledge creation and dissemination more creative, fluid, interwoven, and collective, in contrast with many other western methodologies that are more commonly accepted which are more linear and rigid. From my experience, western academia has been more likely to discredit narrative research more often than positivist research. I also valued the expression of collective engagement used in a dual narrative methodology. Duo-ethnography has given me the confidence to explore narrative more fully.

Future Directions for Social Work Practice

Many changes toward equity in social work practice have been and continue to be led by Black, Indigenous and racialized and equity-deserving people who are practitioners, scholars, community members, service-users, and students. Future directions for equity in social work include following the lead of these people. An option to learn more includes the resources with Black, Indigenous, and racialized contributors in the additional resource section for further reading. Reflexivity and critical action with rural service-users based on anti-oppressive practice are to be guided both by the Black, Indigenous and racialized, and equity-deserving people who have and continue to benefit the field with their voices and actions. While writing this chapter, there was a concern that focusing on our stories could re-centre whiteness, as the authors identify as white. We chose to try and counter this by following the lead of Black, Indigenous and racialized people's voices and applying their wisdom to our own examples to become a way of drawing attention to the invisible burden of educative labour that disproportionately falls on people already experiencing marginalization. This chapter is an example for readers about what some white settler individuals are doing through using reflexivity to adapt their personal and community narratives towards a more equitable future.

Reflections on Hope

We both felt that our perspectives on rural equity in social work contained hope. I (Denise) wrote, "Just because the current situation is so persistent does not mean that meaningful work to change it is not already being and cannot further be done. Social work can always continue to move in more decolonial and anti-oppressive directions and towards more equitable, peaceful and autonomous futures." I (Michelle) wrote, "There is great potential in rural areas for decolonizing because the relationships [to land, to the more-than-human world] are already there."

It is not enough to be intellectually anti-oppressive; we must use the agency available from privilege, giving up power and pushing against or even leaving certain institutions. These acts do not guarantee any form of justice. However, it is far more harmful to do nothing. Systems do not dismantle themselves. Therefore, for us, hope is found in continuous action, and in seeing the results of those actions living in the younger generations.

In this chapter, we have used interprofessional and inter-geographical collaboration to explore our journeys of critically deconstructing previously held beliefs and have looked at how these beliefs also shape social work in rural places. This process has and continues to be an uncomfortable one. However, the work is also fundamentally hopeful, as the discomfort signals us that we

are still invested. If we did not care, we would not feel any discomfort. Maya Angelou said, “When you know better, you do better” (Oprah Winfrey Network, 2011). Because we care, we continue to believe that we can do better, and we work towards that aim.

Key Takeaways

We have several key takeaways as you reflect on your motivations and journeys to becoming an ethical, anti-oppressive social worker. These are offered as thoughts for future directions and to inform the activity assignments in the following section.

1. Reflexivity is crucial to anti-oppressive practice. The adage what you don’t know can’t hurt you is dangerously false. What you don’t know can hurt you – and others as well. Spending time to reflect on personal motivations, systems of belonging, and examining current forms of responsivity can strengthen practice. Deconstructing dominant ideas taught about “helping” can assist in developing an anti-oppressive practice. Action resulting from reflexivity is the most crucial step in the process.
2. Whiteness pervades mainstream social work in Canada. If you identify as Black, Indigenous, and/or racialized, this is probably already obvious. Even though much social justice work can be heavy, thank you for your presence in this work and for using your knowledge and skills to benefit the communities around you. If you identify as white, it might be difficult for you to identify the pervasiveness of whiteness. Whiteness is not “neutral” but a specific culture, complete with values and ways of doing things. Question why whiteness is often the default in settler social work systems and seek to unlearn its supremacy by listening and engaging with the Black, Indigenous, and racialized and equity-deserving communities around you.
3. Displacement is often the result of the lack of equity and social services available in rural communities. Rural communities face unique challenges, and displacement has a long history and legacy. Recognize how it works and challenge it where you can.
4. Social workers must navigate dual relationships in rural communities. There are different ways of dealing with this complexity. Be thoughtful and creative in how you address these complex issues.
5. Certain social work positions may be more associated with decolonial values than others. Pay attention to institutional racism and other forms of oppression present in the organizations you may work for and see if you are contributing more to challenging it or upholding it in your position.
6. Approaches to practice such as strength-based and person-in-environment may be conducive to anti-oppressive practice by acknowledging users’ lived experiences and social contexts. Reflect on which social work frameworks may assist you in anti-oppressive practice.
7. The application of anti-oppressive practice to the CASW Code of Ethics, Values and Guiding Principles needs to be addressed by social workers. Using reflexivity, self-assessment of one’s power in the context of the values that guide the helping relationship can lead to a more ethical approach. CASW is not immune to institutional oppression. As individual social workers and as a collective, reflexivity must also take place.

Michelle Lam (she/her) is a 39-year-old white woman who grew up in a small hamlet in the Manitoba prairie. She is influenced by a conservative evangelical Christian upbringing and a rural white settler community background. These often closed spaces led to her interest in innovative research methodologies, storytelling, and arts-based methods as they have the potential to disrupt and unsettle unexamined narratives. She is interested in making research and research findings meaningful, accessible, and useful in rural places, which springs from her early communities of belonging. Dr. Lam completed a Ph.D. in Education at the University of Manitoba, where she explored the ways newcomers are welcomed (or not) in rural spaces, and how racism and colonialism impact these experiences. In her current work, she uses film to explore experiences of racism, and looks at the potentials of social media to disrupt and push back against harmful narratives.

Denise Humphreys: I come from a white Ukrainian/European family, I am a settler, and was brought up primarily from a western worldview. I also live in the world as a cis woman who is part of the 2SLGBTQIA+ and disabled communities. Although not always explicitly, this chapter was written with these influences. These elements of my identities are connected to what can often be found in the social work field—colonialism and in this case its inextricable ties to eurocentrism, racism, sexism, anti-queerness, and ableism.

I also have only lived in urban areas. My experiences are limited to my connection to others from rural places and through working with Brandon University’s Centre for Applied Research and Education in Rural, Remote, and Indigenous Settings (BU CARES). In this chapter, Michelle brings her experiences of rurality to the text, while I bring my experiences in social work. I am also learning more about rurality through my involvement in this textbook.

Exercises

- Think about the popular movies you may have seen, where helpers (often with little training or experience or cultural awareness) make "grand changes" in the lives of those they are helping. These tropes are not accurate and can lead to harmful dynamics. Spend time thinking about what it means to help in an ethical, humble, and loving way. As you reflect on your own future practice, think about factors that you may deconstruct for anti-oppressive practice pertaining to race, class, gender, and disabilities, etc.
- How might you confront the colonialism of western social institutions in your practice? If your workplace has decolonial values or you and/or others have some decolonial actions in your practice, how might you maintain this?
- What social work frameworks will guide and add value to your practice with rural peoples in rural or urban settings? How might you apply these frameworks relationally and at 3 different levels of practice with rural peoples (i.e. micro, mezzo, macro)?
- How might you apply the CASW Code of Ethics, Values, and Guiding Principles when working with rural peoples in practice? Can you identify benefits and limitations of the code and how you might find balance? Consider issues of displacement, colonization, and availability of services.

Additional Resources

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1. In this chapter, we use the term “Black, Indigenous, and racialized people” and “white” often when discussing racial and ethnic identities and how they relate to equity, anti-racism and anti-colonialism. We know terms like these have limitations in their use and often evolve to better understand current identities and power relations. Future editions of this text may reflect this evolution. In addition to this, when data from a source is cited, the terminology used in the source is retained. ↵
2. Italics are used when quoting directly from our duo-ethnographic dialogues that shaped this chapter. ↵

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Practice Competencies to Effectively Support Wellness for Social Workers and Clients in Northern Saskatchewan Communities

4

Wanda Seidlikoski Yurach; Carrie LaVallie; and Vivian R Ramsden

Social workers carry out trauma counselling services in northern communities because this kind of work requires someone with a generalist background who can practice independently (Coholic & Blackford, 2003; Graham et al., 2008). Delivering trauma supports in northern Canada, social workers most often use the title of mental health therapist or mental health provider (Assembly of First Nations, 2015; O'Neill et al., 2016). Northern communities have difficulty retaining mental health providers/social workers because outside of northern communities, very little is known about what is needed to support their well-being to carry out this work (Mental Health Commission of Canada, 2012). Kiawenniserathe Benedict (2015) contends that northern human service work including social work is extremely challenging and believes healthy/supportive workplaces are required to mitigate the range of demands. Therefore, social workers need access to evidence-informed practice competencies to protect their well-being in order to create psychologically safe work places to carry out northern trauma work effectively and sustainably and in turn improve services for and with northern clients (Seidlikoski Yurach, 2021). Although the main focus of this chapter is northern social work practice competencies, rural Canadian social workers may have similar experiences, such as limited access to well-being supports and isolation from professional colleagues (Goodman, 2012). The information covered in this chapter includes: a review of the complexities of working in northern communities; social work practice barriers/challenges for social workers in northern practice; practice competencies that support/protect the well-being of northern clients and social workers; an overview of micro, mezzo, macro skills; as well as discussion questions, activities, and references. Overall, this chapter addresses the following question: What are the practice competencies and supports social workers require to protect their well-being in order to navigate central complexities of northern practice and provide a relational participatory approach to service delivery in northern communities? This question is answered by explaining the unique complexities of northern social work trauma practice, adapting social work practice competencies to incorporate the well-being of workers, and exploring ethical and sustainable undertakings at the micro, mezzo, and macro level.

Learning Objectives

By the end of this chapter you will have had the opportunity to:

- Be aware of the complexity of Canadian northern and rural social work practice in order to create a safe work environment and mitigate ethical dilemmas.
- Learn how to employ a relational participatory practice approach through critical reflection and enhanced well-being in order to help others.
- Learn how to apply ethical and sustainable social work practice competencies at the micro, mezzo, and macro levels when working with communities in northern Canada.

Complexities of Working in Northern Communities

New social workers in northern communities have often reported experiencing culture shock and difficulty fitting in (Cruikshank, 1990; Zapf, 1993), and Indigenous clients reported feeling guarded about non-Indigenous social workers/counsellors/therapists in their communities (Morrissette & Naden, 1998). Northern social workers have often faced trust issues with their clients whether from inside or outside the community. Therefore, workers need to use a generalist trauma-informed approach to build trust with clients to effectively carry out services while at the same time protecting their own health and well-being (O'Neill et al., 2016; Seidlikoski Yurach, 2021). As well, northern communities are closely connected and as a result, professionals such as social workers often encounter situations that challenge their Codes of Ethics, such as dual relationships and lack of confidentiality (Bishop & Schmidt, 2011; Galambos et al., 2006; O'Neill et al., 2016). Social workers provide trauma counselling within Indigenous communities that have experienced elevated rates of emotional pain along with reduced access to needed services (Hackett et al., 2016; Lavoie & Gervais, 2012). The lack of resources and increased demand for services demonstrate the complexity of working in northern communities.

Formal mental health professional service providers, which included social workers, were studied in a multi-phase project in the following Canadian locations: Yukon, British Columbia, Alberta, Northwest Territories and Nunavut (O'Neill et al., 2016); the purpose of the study was to identify and hear experiences of providing trauma support in isolated locations. Although trauma providers reported increased levels of compassion as a result of working in northern communities, they also talked about feeling emotionally empty due to the long hours they were required to work (O'Neill, 2010). As well, providers have reported quitting their jobs or leaving trauma care altogether when they were unable to balance the demands of the work (Harrison & Westwood, 2009; Kanno, 2010), or to manage the emotional distress they were experiencing (Bride, 2007).

Despite their commitment to their clients and communities, northern social workers described having encountered the following barriers: high complex-trauma caseloads, limited self-care resources, insecure program funding, and high rates of staff turnover (O'Neill et al., 2013). Humility and confidence are required to maneuver the barriers within isolated northern trauma work, which can be especially difficult for a new social worker (O'Neill et al., 2016). The complexities, isolation, and high trauma case loads in northern social work can increase one's risk of secondary trauma further discussed in the next section.

Isolation and Secondary Trauma

Isolation is a significant obstacle for northern trauma workers and limits their access to colleagues and clinical supervision (Coholic & Blackford, 2003; O'Neill et al., 2016). Also, the demanding nature of remote northern trauma work is exacerbated by the isolation and may increase providers' vulnerability to secondary trauma (O'Neill, 2010). Secondary trauma can include mental health effects such as inability to trust, and loss of freedom and safety (cognitive shifts); upsetting or lack of feelings, increased startle response, and the inability to carry out normal activities (psychological distress) (Collins & Long, 2003); and feeling disconnected from friends, family, and one's clients (Elwood et al., 2011).

Distress or secondary trauma due to trauma counselling is described in the literature using several terms including secondary traumatic stress, burnout, and compassion fatigue (Collins & Long, 2003; Elwood et al., 2011; Hensel et al., 2015). Although this variation in terminology creates some challenges in comparing results, there appears to be agreement in the literature that secondary traumatic stress occurs because of wanting to alleviate the emotional pain of a client (Figley, 1995). Secondary trauma symptoms can develop rapidly and intensify into secondary traumatic stress disorder – much like Post-Traumatic Stress Disorder (PTSD) (Figley, 2002). Furthermore, PTSD diagnostic criteria now includes the repeated indirect exposure to unpleasant details of events that are traumatic (American Psychiatric Association, 2013). Consequently, the Mental Health Commission of Canada (2013) recommended that "labour laws, occupational health and safety, employment standards, workers' compensation, the contract of employment, tort law, and human rights decisions are all pointing to the fact that employers must provide a psychologically safe workplace" (p. 53).

Listening to understand the emotional pain of another requires empathy, but it also often results in impact on the therapist (Pearlman & Saakvitne, 1995). Trauma counselling involves listening to clients' horrific stories and can negatively impact a worker (Hensel et al., 2015; O'Neill, 2010). Workers primarily dealing with traumatized clients are reportedly more likely to experience secondary trauma (Bride, 2007; Pearlman & Mac Ian, 1995). Bride (2007) reported that more than 70% of social workers providing trauma support in her study experienced at least one symptom of secondary traumatic stress, and 15.2% met the criteria for PTSD. Many northern human service providers also identified experiencing attributes consistent with secondary trauma such as loss of compassion, lack of sleep/exhaustion, and hypervigilance (O'Neill, 2010). As a result, northern providers experiencing high levels of distress can often struggle to meet the needs of their clients as well as their own (O'Neill, 2010).

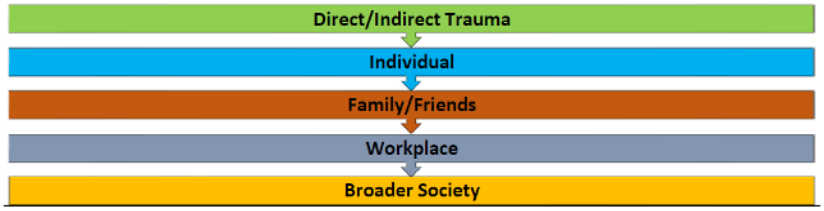
Significant secondary traumatic stress risk factors include: a worker's age, years of experience, personal trauma, trauma caseload, and access to personal as well as workplace supports (Hensel et al., 2015). Being new to the job was found to be the strongest work-related predictor of secondary trauma (Devilly et al., 2009). In addition, secondary trauma contributing factors specifically related to practicing in northern Canada were reported to include: worker's trauma history; listening to trauma narratives; observing a client's physical trauma wounds, and insufficient capacity to deal with stress (Bishop & Schmidt, 2011).

Trauma workers can also sometimes struggle to separate themselves from their clients' stories because of their own unhealed trauma (Bishop & Schmidt, 2011; Ludick & Figley, 2016). Workers with unresolved trauma may generate protective emotional barriers that can undermine the therapeutic relationship (Collins & Long, 2003). Ludick (2013) recommended that human service providers detach from their clients' trauma stories, because those who can do so are the least negatively impacted by their work. Also, social workers who interview for solutions and focus on their client's resilience are better able to reduce their own risk of secondary trauma, even when they have trauma histories similar to those of their clients (Morrisette & Nadan, 1998). Social workers must often be the ones who set measures in place to support their well-being (Bercier & Maynard, 2015). For example, to reduce the likelihood of secondary trauma, a social worker must clearly define and protect their own empathic boundaries to maintain their well-being and capacity to work with their clients (Ludick & Figley, 2016). As well, workers experiencing secondary trauma

should discontinue providing services as this is not healthy for themselves or their clients (Bride, 2007; Harrison & Westwood, 2009). Social workers also need to understand that the negative emotional and psychological implications of trauma counselling can also extend to their own family and other people close to them (Pearlman & Saakvitne, 1995; Westman & Bakker, 2008). For example, social workers in northern Saskatchewan report sometimes being unable to connect emotionally to their family (children/partner) and friends (Seidlikoski Yurach, 2021). Figure 1 demonstrates the linkages between direct and indirect trauma and the trickle-down effect from social worker to the broader society.

Figure 1

The Broad Reaching Implications of Direct and Indirect Trauma



Note. Adapted from Crisis & Trauma Resource Institute (2021).

The job demands of northern and rural social work, including time away from home, affects both the worker and their family. Social workers also identified that isolation and secondary trauma negatively affected their cognitive and psychological well-being. Northern practice creates unique challenges that require social workers to be aware of strategies and competencies to strengthen/support their own well-being, their families', and their clients'. Well-being and safety-supports at the individual and organizational levels are vital for northern social workers to manage the potential impact of their work (Barrington & Shakespeare-Finch, 2014). These strategies will be discussed in the next section.

Supporting and Protecting the Well-being of Northern Providers

O'Neill et al. (2016) argued that the implications of indirect trauma exposure are especially of interest for human service providers working in remote locations in Canada. To protect the well-being of providers, including social workers in isolated northern communities, workers must effectively use local community services and supports; they must be open to adopting cultural and trauma-informed practice competencies (O'Neill et al., 2016). Goodwin et al. (2016) recommended that an interdisciplinary team approach should be a job expectation for mental health workers in northern Canada to better meet the needs of the community, and to offset the effects of isolation. For example, social workers need to actively seek out and establish relationships with a broad range of community supports such as Elders, nurses, teachers as well as parents and youth to develop a collaborative/collective toolkit of services that could be delivered. These community connections help to increase supports to clients and in turn reduce the isolation from one's peers/colleagues experienced by northern social workers.

In 2013, four Saskatchewan First Nations Tribal Councils piloted a project to develop/train community-based mental wellness teams and support linkages between local trauma-informed formal and informal resources (Hill et al., 2016). Social workers in northern communities can also link into these interdisciplinary teams for increased support. Another method of supporting a team approach would be to connect northern providers/social workers through a "community of practice" to provide a platform for workers to engage and discuss innovative methods of practice (Wenger & Snyder, 2000) collectively and supportively. The term "community of practice" was defined by Wenger and Wenger (2015) as "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (p. 1). A "community of practice" requires: a common purpose or concern; relationships that support participants capacity to learn and offer learning to others; collaborative building of capacity by sharing solutions to recurring issues; and a forum to discuss experiences and methods of practice (Wenger & Wenger, 2015).

Lawson et al. (2009) argues that northern social workers require support strategies to reduce the isolation and work demands to prevent burnout and job attrition. These support strategies include provision of resources to reduce isolation; training to expand one's knowledge and skills; and supervision to develop effective practice competencies and supports (Lawson et al., 2009). In addition, northern Canadian providers have identified a need for formal clinical supervision, teamwork, routine debriefings, and access to informal supports such as friends and/or family to provide services over the long term (Bishop & Schmidt, 2011; O'Neill et al., 2016). McKee and Delaney (2009) propose that northern social workers partner with communities to meet their identified needs. Authentic and sustainable partnerships must be based on "context-sensitive knowledge for practice" (McKee & Delaney, 2009, p. 330). Through a participatory narrative inquiry study lens, the next section introduces practice competencies specific to protecting the well-being of northern-based trauma support social workers.

Key Practice Competencies for Northern Social Workers

A brief overview of a participatory narrative inquiry of trauma-support social workers will be discussed to understand their experiences in northern Saskatchewan. It is important for social work standards of practice specific to northern and rural practice to be research-informed. Through the stories, we can gain valuable insight specific to providing trauma-informed services that also supports the well-being of social workers. Ten trauma-support social workers with experience working in northern Saskatchewan's Indigenous communities were interviewed regarding their lived experiences. They made the following recommendations to improve providers' sense of belonging and safety and to ease the overall impact of job demands. These included: adopting a team approach; building strong working relationships with supervisors/managers; and expanding overall access to formal supports including a "community of practice" (Seidlikoski Yurach, 2021). Social workers involved in the study also provided recommendations about practice competencies including: collaborative/relational participatory skills; a continual process of critical self-reflection of one's knowledge/values; practice through a reconciliatory trauma-informed lens, employing cultural humility; and improving northern workplace well-being and safety supports (Seidlikoski Yurach, 2021).

The standards of practice developed by the Saskatchewan Association of Social Workers (SASW, 2020) in 2020 set out the competencies which registered social workers in the province must adhere to for the benefit of their clients; these competencies include ethics, advocacy, culture-based interventions, collaboration, and new insightful methods of engagement/intervention. Although standard practice competencies provide a basic and consistent level of expectations, they might limit social workers to more mainstream ways of approaching their practice. Therefore, we propose that northern social workers strive to develop the following northern practice competencies:

1. Encouraging social workers to connect with other social workers to build a strength-based collaborative "community of practice"
2. Understanding the context of northern communities
3. Engaging in critical self-reflection and cultural humility
4. Engaging in a relational participatory reconciliatory approach to meet the service needs of northern communities while recognizing ethical dilemmas such as dual roles.
5. Utilizing trauma-informed practices
6. Supporting workplace safety and wellness

Building authentic supportive relationships within northern communities and connecting with outside resources/supports, clinical supervision, and standards of practice are instrumental to the well-being/resiliency of northern social workers to sustain service provision. In addition, understanding Indigenous peoples' trauma history is needed in order to support and protect well-being.

Importance of Northern Social Workers Understanding Indigenous Peoples' Trauma

Social workers who want to work in northern Indigenous communities need to understand how intergenerational trauma and the negative health implications associated with such trauma have developed because of colonization (Truth and Reconciliation Commission of Canada [TRC], 2015). A recommendation from the Assembly of First Nations (2015) was to establish a process to support "existing and future providers from Western-trained programs in developing cultural safety, trauma-informed practice approaches, harm reduction skills, as well as a deep historical understanding of First Nations health, ongoing colonization, intergenerational trauma, and its effects" (p. 27). In addition, one of the TRC's Calls to Action (2015) is provision of "cultural competency training to all healthcare professionals" (p. 2). Allen and Smylie (2015) strongly suggested that mental health providers should be trained in "cultural competence, cultural safety…

and trauma-informed care" (p. 36). As discussed earlier in this chapter, the Saskatchewan Association of Social Workers (SASW, 2020) has developed practice competencies that include cultural competence. Therefore, all social workers, but more importantly those that work in northern Canada, must take steps to practice competently. Social workers must learn their own family histories, cultures, and ways of thinking, along with those of their clients, so they can integrate this information into their practice (SASW, 2020).

When providing social work support and counselling support to Indigenous peoples, one must prioritize learning about colonization, along with the current systemic inequalities and racism that create ongoing trauma (Stewart, 2009). It is imperative for providers to be aware of the history of Indigenous peoples in order to understand the circumstances that have created the trauma within the communities in which they work (Stewart, 2009). Social workers need to understand that Indigenous peoples in Canada have been subjected to a purposeful strategic process of assimilation through colonization (Thompson et al., 2010). For instance, the forced removal of Indigenous children to attend residential schools undermined their culture and family bonds (Ross, 2014; TRC, 2012), and created mass intergenerational and interpersonal trauma that continues today (Thompson et al., 2010).

To strengthen the self-determination of Indigenous peoples and communities, social workers in northern communities must engage in a continuing process of self-reflection and fully appreciate the direct link between the history of Indigenous peoples and the current issues faced by northern communities. Allan and Smylie (2015) argued that understanding and reflecting on the impact of racism helps generate a process of decolonizing the delivery of services for and with Indigenous peoples. Social workers engaging in northern practice must actively understand, believe in, and fully participate in reconciliation efforts. As an active participant in reconciliation, one must engage with a curious mindset and self-reflection that supports an openness to learning. An overview of this process will be provided in the next section.

Learning Through Curiosity and Critical Self-Reflection

Northern Canada is more than just a geographical region for Indigenous peoples; it is home, has a sense of purpose, and is sacred (Schmidt, 2009). Professional supports for those working as social workers in northern Canada must have a broad understanding of the "traditional worldview of Aboriginal People" (McCormick, 2009, p. 338). Culturally-uninformed service providers might unknowingly undermine their Indigenous clients' beliefs, thereby generating additional stress (McCormick, 2009). Health and social service providers need to engage in a process of self-reflection regarding their personal values and cultural principles when working with Indigenous peoples (Moss et al., 2012) as shown in Figure 2.

Figure 2

Components of Critical Self-reflection

How would you describe your own personal history, culture, traditions, and language? Where did you grow up? Who did you grow up with? What are your values and beliefs?



Note. Adapted from (Fook et al., 2006).

Furthermore, information as to how racialized social workers (Weinberg & Fine, 2022) and LGBT2S social workers (Mule & Hillock, 2016) navigate the nuances of remote and rural practice is very limited and generally does not extend beyond the scope of institutional studies of social work students. In one study O'Neill et al. (2016) examined the lived experiences of mental health providers working in northern Canada. Indigenous social workers from the communities they worked shared that clients were reluctant to see them because of fears regarding confidentiality including having extensive knowledge about community members (O'Neill et al., 2016). Social workers from the community and from outside the community appear to face roadblocks in building trust (O'Neill et al., 2016; Seidlikoski Yurach, 2021). As such, one could argue there is an opportunity and obligation to explore the challenges/roadblocks to which only those social workers in remote or rural settings with the lived experience of being racialized and/or LGBT2S can describe.

Fitting into a remote or rural community as an outsider takes time and understanding the roadblocks is imperative. In addition, outsider social workers working in remote or rural communities need to understand the history and culture of the community to which they will be working in. As well the community needs to provide opportunities for outside workers to share their culture and history within the community. Therefore, as a racialized social worker See-Toh (2012) argues "you need to have a strong voice to advocate not only for clients but for yourself as a racialized person" (p. 154). With that said, a general recommendation for any social worker in a northern or rural location is to either create or join an established community of practice of social workers (Seidlikoski Yurach, 2021). This would provide an opportunity to meet on a regular basis to discuss the challenges, successes and practice strategies that help each of us to navigate the complexities of northern work.

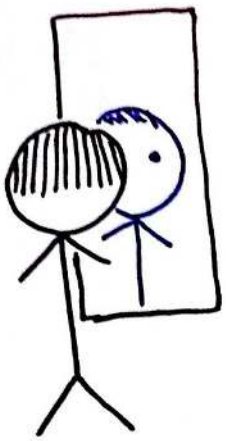
McKee and Delaney (2009) suggested that northern social workers need to understand the complexities of each community and suspend or change their own beliefs and ideas in order to provide appropriate anti-oppressive services. McKee et al. (2009) provides a list of critical self-reflection questions for social workers in these communities:

1. What knowledge am I attempting to bring to this situation? Where did I learn this? How is this learning getting in my way?
2. Why is this way of making sense of this situation so automatic to me? Why is this pet theory so dear to me? Why am I having trouble giving it up so that I can approach this situation differently?
3. Whose voice is being heard in this knowledge I take to be so real? Is it my own, based upon my own authentic experience, or someone else's? What aspects of my own experience are being misrepresented or silenced by this knowledge I take so much for granted? (p. 202). This self-reflection process is further demonstrated in Figure 3, and you are encouraged to engage in your own process of self-reflection by using these questions and process as a guide.

Figure 3

What is your reality?

How would you answer the above noted questions? What might get in the way of you being able to answer these questions? How has your reality been formed?



Note. Adapted from (McKee et al., 2009).

Stories can be an effective way to set the stage for self-reflection and curiosity. For example, an Elder sat with two colleagues one morning to enjoy some conversation over a cup of coffee. The conversation began with pleasantries and then turned to the topic of grief. At that point, one of the colleagues expressed that they did not want to engage in such a serious discussion. This was supposed to be a pleasant morning of coffee and conversation. The Elder picked up on this tension and chose to tell a story in order to intervene. He began his story by asking "Did you know I'm writing a book"? To which his colleagues replied, "No." He said "Yes, it's called looking at the world through a pin hole in a blanket. It's about a boy who can only see the world through this pinhole, but as he is more curious to see the world, that pinhole expands and he is able to see so much more." The two colleagues looked at each other and then at the Elder. With a smile, they realized that no more needed to be said; they ate their breakfast, drank their coffee, and enjoyed each other's conversation. The story shared by the Elder created space for everyone at the table because each of the colleagues had a choice about its message. One such message might be that a person's defensiveness can keep them from seeing all that there is to see. When you get frustrated or defensive, remember this story and be aware that sometimes we all need to be silent and listen. As well, we may not know what there is to learn in a particular moment, but through a process of reflection we will learn something from it. This story resonates with social workers as we focus much if not all our attention on the needs of others. This is how we view the world through the "pinhole in our blankets." Although focusing our attention on the needs of clients is an important aspect of trauma-informed practice, we must expand our view to include the needs of social workers as well.

Workplace Safety and Wellness – Trauma-Informed Practices and Supports

To better support clients in healing their trauma, counsellors, and social workers themselves require safeguards in their workplaces to shield them from secondary traumatic stress (Kanno, 2010). In order to learn how to effectively work in northern communities one must actually work in a northern community (Seidlikoski Yurach, 2021). There is no textbook that can quite prepare someone for the work that they will do in northern communities. One must hit the ground running and do whatever is placed in front of you (Seidlikoski Yurach, 2021). Social workers must understand the implications of working with trauma stories. They must also understand that they are all part of the colonial trauma history as well as the colonial practices that continue in Canadian society today.

Human-service providers require confidence, competence, and compassion, with the emotional capacity to cope with the demands of trauma work (Ludick & Figley, 2016); those who feel more confident in their skills are less likely to experience burnout or compassion fatigue (Ortlepp & Friedman, 2002). Social workers are more likely to enjoy their job (compassion satisfaction) and be protected from fatigue and burnout when they assist others, have positive co-worker relationships, and promote wellness both at work and more broadly (Stamm, 2010). Further recommendations by Ludick and Figley (2016) include the importance of screening potential employees to determine their suitability for trauma work and requiring employers to develop workplace wellness supports to protect workers from secondary traumatic stress.

Social workers truly informed about traumatic learning are required to commit to conscious participation in creating greater safety for their clients and for themselves. Zingaro (2016) argues the focal point of social work is to develop relationships that incorporate and contextualize trauma while "providing support, information and understanding and as much experience of safety as we can manage" (p.35). Safety includes self-care, which is a significant factor in the well-being of providers including social workers (Wieman, 2009), supporting a worker's capacity to adapt to challenging situations (Salston & Figley, 2003). Nelson-McEvers (1995) defined self-care as learned patterns of action and strategies to preserve or protect overall health. Kaushik (2017) argued that social workers' self-care needs must include engaging in a process of maintaining or repairing their own emotional well-being and explains the following:

> Pain, despair, and suffering equally affect us as they do to the clients we serve. … How can, we, the service providers, claim to help our clients deal with their suffering if we cannot ameliorate our pain? Just as a drowning person cannot save other drowning people, we the social workers cannot heal others unless we heal ourselves. (p. 27)

Providers working in remote northern communities in Canada have also identified the desire to incorporate trauma-informed practices into their work as a strategy to support and protect their emotional and psychological well-being (O'Neill et al., 2016). Trauma-informed practice competencies involve understanding the impact of trauma on clients and helpers, and implementing the most appropriate/effective method of treatment (SAMHSA, 2011). Thus, it is important to spend time in the community with community members building relationships and learning (Canadian Institutes of Health Research et al., 2018).

Northern communities have a keen sense of connection bound by geographical location, landscape, and kinship, as well as cultural practices. Outsider mental health providers learn about the community they are working in by talking with Elders and residents (O'Neill et al., 2016). Social workers wanting to participate in northern community work must understand that they will face many challenges, but they will also have the honor and opportunity to understand and immerse themselves within an authentic community participatory experience (Schmidt, 2009). Being competent in one's skills to work in northern practice includes a relational participatory approach. By seeming to understand the trauma of northern clients and by doing so through a trauma-informed lens, social workers are not only able to better work with and for clients in northern communities, but are also better able to support/protect the needs of themselves and other social workers (Seidlikoski Yurach, 2021).

Relational Participatory Approach to Social Work in Northern Practice

Folgheraiter and Raineri (2012) suggested that "in genuine relational social work, there is not one party who seeks to provide well-being to another; everybody pursues the well-being of everyone else together" (p. 480). As well, "in any helping relationship, the help is only produced when the worker accepts help from the interested parties as if they themselves were workers" (Folgheraiter & Raineri, 2012, p. 484). To work competently within a relational participatory approach, social workers must also acknowledge everyone's humanity including their own (Folgheraiter & Raineri, 2012); they must view all relationships as essential, including those with clients, co-workers, and supervisors (Ruch, 2009). For social workers to effectively work within northern communities, they must genuinely and authentically engage in developing strong, trusting, and mutually-respectful relationships with their clients and the community.

Winter (2019) maintains that relational practice is based on "being real, committed, responsive in thoughtful ways; and also, being able to regulate one's own emotional responses and react responsibly to the emotions of others" (p. 13). For social workers to practice relationally with clients, they must understand that transformation and growth occurs because of the relationship; healing can occur even though the relationship is not equal; and positive results require working together through their connected worlds "interpersonal, intrapersonal and structural" (Winter, 2019, p. 13). Howe (1998) advises a relational participatory approach requires social workers to acknowledge their personal traits or nuances and how this might impact the client and the worker. Moreover, a relational participatory approach requires competent oversight, guidance, and facilitation.

Social workers should anticipate that many of the relationships they will engage in professionally within northern communities will have ethical complexities such as dual roles and boundary issues. To assist the social worker in navigating ethical dilemmas, they can be encouraged to refer to documents provided by social work regulatory bodies, as well as colleagues, for guidance. For example, the Saskatchewan Association of Social Workers (2020) outlines the following standards of practice required to protect the client when dual relationships are likely to occur:

1. Consult with another social worker regarding the dual/multiple role relationship and subsequent provision of professional services to the client and include the contents of the consultation in the client's record.
2. In all cases when a dual/multiple role relationship exists the social worker is solely responsible for ensuring that appropriate professional boundaries are maintained, and that the client-social worker relationship is protected.
3. Where a social worker's personal circumstances result in frequent contact with clients outside the practice setting, a social worker shall take reasonable measures to discuss with all clients how contacts outside the professional context will be managed to protect the client's interests (p. 23).

Building relationships, although key in effective northern and rural practice requires a careful balance between developing specific skills beyond the scope of empathy to include sincerely caring for another while putting in safeguards to protect one's client. The relationships need to be reciprocal and consider not only the well-being of the client but that of the social worker. In the next section, we will further examine why northern community relationships need to be meaningful with suggestions for how this might take place.

Building Meaningful Client-Worker Relationships – Care and Love

Delivering mental health services in northern communities requires social workers to build genuine/authentic participatory relationships with clients and communities so that they can work collaboratively and competently. McCormick (2009) recommended that provider/client relationships must be collaborative not only to provide safe services to clients, but also to protect the safety and well-being of providers. Building relationships, particularly for outsiders in Indigenous communities, takes time due to the historical implications of colonization. It is important to remember that "social work discourses have never given permission for us to love the people we work with, although words such as care, empathy and compassion have long been used" (Massing, 2017, p. 174). Social workers working in northern Saskatchewan Indigenous communities have described "loving" the people and communities they work in and how heartbreaking it is when they leave (Seidlikoski Yurach, 2021).

Rollins (2020) argues every social work relationship is purposeful and unique requiring "a sustained focus on intervention, purpose and goals. At the same time, social workers are focused on developing, retaining, retrieving, and repairing these relationships that in turn, can also enhance the client's own relationship capacity" (p. 399). One of the most important aspects of working in northern Indigenous communities is to patiently hold the necessary space for trusting relationships to develop. For example, northern Saskatchewan social work mental health providers indicated that longer term work within Indigenous communities was more effective than short term crisis-work, because trusting relationships take time to develop (Seidlikoski Yurach, 2021). Building relationships within northern Indigenous communities helps to improve the social workers' access to local supports, which in turn helps to buffer the impact of isolation.

Building relationships requires being respectfully curious and learning about the community. It is important to find out what the community wants/needs and then explore and develop solutions together (Kurtz, 2014). Each relationship will have its own unique complexities and take time, often years, to develop (Mayan & Daum, 2016). Each relationship within northern communities, although timely, is worth every moment of effort when engagement is fully collaborative. It is also important that social workers understand that they are likely an outsider (not from the community), and therefore they should ask permission or wait to be invited to share their opinion. A person must understand that the invitation for them to provide an opinion could take years. Factors such as colonization, being a government agency representative, being an outsider, having western values, and/or being non-Indigenous influence the length of time it can take to build a collaborative, respectful relationship within a northern community. Taking time to develop relationships is key to building trust within northern and rural communities and in turn, helps to reduce the isolation social workers experience especially as a new social worker. Focusing on the strengths of a community and taking steps to work with and for a community at all practice levels supports healing efforts driven by clients and their communities. An expanded discussion of the micro, mezzo and macro levels of practice and its connection to safety will follow.

Micro, Mezzo, Macro Practice Competencies

Social workers, providing services in northern communities, have reported needing to feel safe to effectively carry out their work at a micro, mezzo, and macro level (Seidlikoski Yurach, 2021). To feel safe, it is important for social workers to rely on foundational social-work skills that include building authentic relationships, cultural competence, empowerment, critical thinking, evaluating the effectiveness of approaches, and knowing how to work with at-risk individuals and communities (Austin et al., 2016). Social workers can also feel safer in their work by being able to access supports such as clinical supervision, scheduled debriefings, and safe accommodations; they also need to be part of a work team to carry out collaborative and interdisciplinary northern services (Seidlikoski Yurach, 2021).

Each level of northern social work practice whether micro, mezzo, or macro requires specific skills. For example, a social worker's focus at a micro level is on interpersonal and relational skills whereas at a mezzo level, they must focus on their ability to build broader relationships with agencies in communities that may have competing goals. They try also not to forget the overarching influences of the structural, political, financial, and ideological powers that social workers want and hope to change and adjust to meet the needs of all individuals. We will begin by discussing the micro level skills needed to work in rural and northern communities.

Micro

Social workers must pay particular attention to individual, interpersonal, and group skills which include engaging in self-reflection at a micro skill level to appropriately deal with their own stress as well as their clients' (Austin et al., 2016). In addition, at an interpersonal skill level, social workers must complete assessments, lead teams, and "manage power and privilege to effectively maintain relationships with clients and colleagues" (Austin et al., 2016, p. 273). For example, when working in northern communities, a social worker who does not know the local language can still support their client to tell their story in their first language. The provider does not need to understand the client's story. Finally, group skills are needed to create, empower, and maintain teams and support a process for those teams to follow through with their recommendations for change (Austin et al., 2016).

It is also important for social workers not to go into northern communities focused on healing what they perceive as broken, but instead they should focus on the assets and vitality of the people and community (Barter, 2009). Taking a more strength-based and collaborative approach to practice also creates an opportunity for the community to work together to utilize their own ways of doing and healing (Barter, 2009). The following section will explain how social workers can work with the organizations and agencies within communities to support well-being and healing.

Mezzo

Social workers do many things at a mezzo level in a northern community. For example, workers should take time to visit each northern community agency they work with. During these visits they introduce themselves, explain their role, and spend time getting to know the individuals that work in the different agencies. They do not need to wait for people to come to them; instead, it is important that they make the effort to be engaged with people. Making time to visit those agencies in other communities in the region on a regular basis will build and strengthen relationships and networks. The connections and constructing networks that are instrumental to building multidisciplinary interagency teams have been identified by northern social workers as crucial to their work and well-being. Networking is key not only with agencies within the community but also with those outside the community. External resources include specialized mental health services such as psychiatry, in-patient treatment centres for addictions, and safe shelters. More importantly. the allocation, availability and accessibility of resources are also greatly influenced at a macro level by a variety of political and economic structures. Therefore, the social worker's felt-sense regarding macro level challenges within northern/rural systems will be discussed next.

Macro

Although pursuing social justice is a core value of social work (Canadian Association of Social Workers, 2005) social workers working in northern Saskatchewan have reported feeling powerless to effect change at broader levels such as "structural inequalities and systemic racism" (Seidlikoski Yurach, 2021, p. 131). Social workers providing services in northern Saskatchewan describe their jobs as very demanding and often said that "*focusing on systemic issues were not only overwhelming but would take away from what they believed they could do*" (Seidlikoski Yurach, 2021,

p. 131). Northern social workers acknowledge the importance of systemic changes; however, they often struggle to find the time and energy to focus on these issues. Social workers have identified needing to make the conscious choice to carry out their role at a micro level due to the time demands of northern work. Knowing other social workers have had this common experience can help to affirm and normalize feeling powerless at times in these situations.

Conclusion

Working in northern and rural communities requires knowledge regarding how to address the unique complexities of each community, as well as adopting and adapting effective practice strategies. This includes utilizing a relational participatory approach to better support the needs of clients and foster the well-being of social workers. By understanding the significance of relationships within rural/northern communities, social workers are better able to maneuver the ethical challenges such as dual roles, and more readily adopt a team approach to reduce isolation from colleagues. Overall, northern social workers have identified safety as key to trauma work and support for their well-being, which in turn helps to reduce their risk of secondary trauma. As well, knowing the competing demands of providing services in northern and rural settings can undermine one's capacity to effect change at a systemic level. These practice strategies to assist in meeting the needs of clients, communities and social workers include:

- Social workers seeking to provide effective services and supports must incorporate a relational participatory approach by reflecting on their own trauma history, leading with humility, and supporting clients in telling their story in their own language (Winter, 2019).
- Social work education programs can support and expand training specific to "the development of northern practice skills by adopting a northern perspective based on collaborative partnerships guided by high degrees of context sensitivity and context awareness" (Lawson et al., 2009, p. 303).
- Evidence-informed practice competencies are needed in order to develop ethical, safe, and supportive work places for sustainable social work, including trauma work, in northern Canadian communities. Implementing a "community of practice" can help new and seasoned northern social workers in easing the effects of isolation and secondary trauma (Seidlikoski Yurach, 2021).Type your textbox content here.

Wanda Seidlikoski Yurach: My Indigenous colleagues and friends have taught me to position myself in the context of my relations as well as the area which I was brought up as a decolonizing relational method of introduction. I am a 58-year-old woman of Eastern European decent. I have been married for 38 years, have four children and two grandchildren. I grew up on a farm in southern Saskatchewan, lived in Prince Albert for 28 years, and since September 2018 now call Saskatoon my home. I have filled many roles in my career including being employed with the Saskatchewan Government (Corrections and Social Services) and the Saskatchewan Health Authority (Mental Health). In addition, I maintain a private practice in Saskatoon and work as a Sessional Lecturer at the University of Regina (Faculty of Social Work). I acknowledge my family and relationships are key to who I am. I also acknowledge that the most fulfilling aspect of my career has been working for the last 17 years as a mental health therapist/coordinator in northern Indigenous communities in Saskatchewan.

Carrie LaVallie: I am a third-generation-born white Settler with Scandinavian and German ancestral ties. I have worked with First Nations University of Canada for twenty years and hold a small private practice working mostly with Indigenous peoples. My white skin affords me a position of privilege that is unwarranted but there and should be acknowledged. It is through this privilege that I, at times, believe I have a right to say things in a forthright manner. My intention in co-writing this chapter is not to offend anyone but to assist in making sure all clients are treated with respect by upcoming and current social workers. As a therapist, I pay close attention to people's behaviours and analyze needs. This lens prompts me to offer guidance about what may work for some people and should not be seen as absolutes. This chapter is an invitation to ensure that we are all seeing the client as a person and not as a clinical number.

Vivian R Ramsden: I am a mother, grandmother, daughter, sister, friend and ally of Nordic heritage. I was born and went to High School in Red Deer, Alberta. Following which I attended the Holy Cross Hospital, School of Nursing in Calgary, AB. I went on to complete a BSc in Nursing from the University of Saskatchewan, a Master of Science in Community Health Administration and Wellness Promotion from California College for Health Sciences, and an Interdisciplinary PhD from the University of Saskatchewan. Thus, I am a Registered Nurse who is a Full Professor and the Research Director in the Department of Academic Family Medicine, University of Saskatchewan; and a facilitator of a partnership with a nursing college in Chennai, India; Past-Chair of the College of Family Physicians of Canada's Section of Researchers; and Immediate Past President of NAPCRG (North American Primary Care Research Group). In addition, I was recently elected as a Fellow of the Canadian Academy of Health Sciences.

I am a participatory health researcher engaged in primary health care/family medicine research. I co-create research with individuals and communities that address issues that impact their health and well-being. Thus, in long standing collaborations with Indigenous communities in northern Saskatchewan and South India, and with women released from prison, the outcomes have transformed health and wellness.

Activities and Assignments

- Write down a list of resources for both clients and social workers that you would readily have available in a more urban setting in Canada. Review your list individually or as a group and decide which resources and supports might be inaccessible in a more rural or northern location in Canada. Discuss what would be required to have easier access to these resources.
- Whom might northern social workers develop collaborative linkages with to create workplace well-being supports and safety for all northern social workers?

Additional Resources

- Makokis, P., & Greenwood, M. (2017). *What's new is really old: Trauma informed practices through understanding historic trauma.*
- Rzeszutek, M., Partyka, M., & Gołąb, A. (2015). Temperament traits, social support, and secondary traumatic stress disorder symptoms in a sample of trauma therapists. *Psychotherapy Research Practice & Practice, 46*(4), 213-20.

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Preface

1

Bonnie Jeffery and Nuelle Novik

This second edition has benefited from two peer reviewers who provided excellent suggestions for improvements. Several chapters were edited to include more updated information, introductions to each of the three book sections are provided and most authors chose to accept the invitation to add a positionality statement to their chapters. We also invited authors to submit a powerpoint of their chapter to provide additional teaching resources. Finally, at the suggestion of the reviewers, the subtitle has been changed to more accurately reflect the content of the textbook. These changes have improved readability of several chapters and have stated more clearly the position from which each author is presenting their material. We have appreciated the helpful comments from the reviewers, and we acknowledge that there are some limitations in the textbook. Our general call for chapters through professional social work associations and schools of social work resulted in interest from scholars, educators, and practitioners. We did not direct the focus of each chapter but rather left this decision to the authors. We are aware that the textbook could benefit from expansion to include a greater range of voices, and in particular, the voice of social workers who represent a more intersectional approach to practice. We encourage those using this textbook to consider including additional material to address this.

This book is divided into three distinct parts. Part I focuses on the foundations of this practice by highlighting the importance of context, and by recognizing and respecting *place* using anti-oppressive perspectives. The chapters found in Part II examine practice competencies and emphasize trauma- and violence-informed approaches. The mental wellness of social workers is discussed in detail as a necessary element to ensure resilience and good practice. Finally, Part III of this book explores selected areas of practice including social work with those who have experienced abuse and intimate partner violence, work in the context of mental health issues and addictions, work with newcomers and immigrant populations, work with older adults, and child protection work.

It is our hope that the collective wisdom and ideas shared in these chapters will prepare undergraduate students for practice, and will inspire them to ask questions, to dig deeper, and to fully embrace the unique opportunities for social workers in rural, remote, and northern communities.

In addition to the contribution of the authors, we would like to thank Pamela Reimer for her organizational skills and dedication to this project – we could not have completed this without your assistance. We also acknowledge the financial support for this project that we received from the University of Regina Open Textbook Program.

Bonnie Jeffery & Nuelle Novik

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Rural and Northern Social Work Practice:

Examples within a Canadian Context

Bonnie Jeffery and Nuelle Novik

Amber Miners; Brent McKee; Carrie LaVallie; Cathy Rocke; Colleen McMillan; Curtis Hart; Daniel A. Afram; Denica Dione Bleau; Denise Humphreys; Dillon R. Lewchuk; Hilton King; Joanna Pierce; Judy White; Karmen Pearce; Kristie Panchuk; Laurie Schmidt; Melanie Abbott; Michelle Lam; Natalie Compagna; Tavia McKinnon; Vivian R Ramsden; and Wanda Seidlikoski Yurach

University of Regina

Regina, Saskatchewan, Canada

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Social Work Practice and Mental Health Services Outside of Urban Settings

9

Nuelle Novik; Brent McKee; and Karmen Pearce

This chapter provides an overview of social work practice focused on the delivery of mental health services in rural, remote, and northern communities. As social workers, we know that the prevalence, scope, and range of mental health issues in locations outside of urban centres is significant, and has an impact on the lives of individuals, families and communities. We also know that populations living in these communities don't always have adequate and necessary access to mental health services and supports. In efforts to fill existing gaps in mental health services, social workers living and practicing outside of urban centres are required to work collaboratively and creatively, while utilizing generalist social work practice skills. Increasingly, mental health issues are a growing public health concern in Canada, with mental illness now identified as one of the leading causes of disability (Chen et al., 2020).

This chapter will highlight the characteristics of rural, remote and northern communities that affect mental health service delivery from a social work perspective; it also discusses select mental health-related issues. Attitudes and beliefs that result in stigma related to mental illness, and towards those experiencing mental health challenges, will also be explored.

Learning Objectives

By the end of this chapter you will have had the opportunity to:

- Understand the scope of practice of social workers providing mental health support services in rural, remote and northern settings.
- Describe factors influencing mental health and addictions outside of urban settings.
- Identify common types of mental health concerns found in rural, remote, and northern settings.
- Understand the barriers and enablers for social workers at the micro-, mezzo- and macro-levels of mental health service provision in rural, remote, and northern settings.
- Recognize how the stigma surrounding mental illness affects service access in locations outside of urban settings, and how to identify strategies to reduce that stigma.

What is Mental Health?

The World Health Organization (2021) stresses the importance of understanding mental health as not just the absence of mental illness, but as a concept that applies to everyone under a range of circumstances. The World Health Organization [WHO] defines mental health as a state of well-being in which the individual realizes their own abilities, can cope with regular stresses of life, can work productively, and is able to make a contribution to their community (2021). The Canadian Mental Health Association [CMHA] describes mental illness as a disturbance in thoughts, feelings, and perceptions that is severe enough to affect everyday functioning. Some examples of mental illnesses are anxiety disorders, schizophrenia, and mood disorders such as major depressive disorder and bipolar disorder. Substance misuse is often linked to poor mental health or mental illness (CMHA, 2021). Internationally, and in most jurisdictions across Canada, supports and services are often offered to address both mental health- and addictions-related issues. In the literature, and in practice, mental illness is sometimes referred to as: mental conditions, mental health issues, mental health difficulties, psychological disorders, and challenges to mental health (Baxter et al., 2022; Chen et al., 2020; Lister et al., 2021).

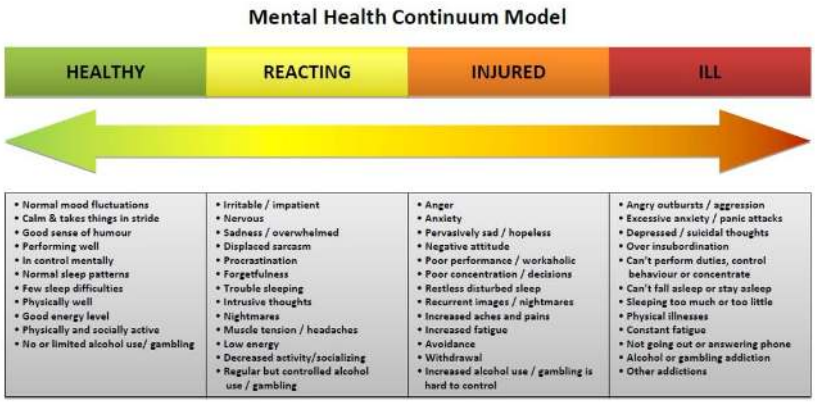
The Mental Health Continuum Model

Within mental health service delivery, the mental health continuum [MHC] model refers to a specific model that has been developed to help with understanding mental health that incorporates a self-help tool. This model is used to:

- Identify the underlying causes of impairment in daily-life functioning;
- Gather information about mental health of individuals over time;
- Indicate when it would be ideal to seek professional assistance for restoring balance in mental health; and
- Learn how to recognize symptoms of psychological disorders (Chowdhury, 2021).

Originally developed by the Canadian Armed Forces [CAF], the MHC model describes four main states of mental health a person could possibly experience. The model is presented as a continuum, which means that a person can move back and forth along the continuum scale and can also land somewhere between the four main areas at any given time (Chen et al., 2020; NSCAD, 2021).

Figure 1



(Source: CAF as cited in Chen et al., 2020)

In a more general sense, the mental health continuum refers to a range of mental wellbeing with **mental health** and **mental illness** at the two extreme ends. Depending upon the circumstances of an individual at any given point in time, he/she/they can be situated at one point of the continuum but can actually shift position as their situation improves or deteriorates, which is seen as being an effective way to interpret mental health (Allport, 1937; Chen et al., 2020). Consistent throughout the literature is the acknowledgement that there is a place for everyone on the mental health continuum (Chen et al., 2020; Chowdhury, 2021), and that this approach can potentially reduce stigma due to the idea that *everyone fits in*. The model is intended to serve as a self-reflection and self-monitoring tool, with colours indicating the level of severity of illness. By incorporating colours, the intention is to further reduce stigma by limiting use of jargon and reducing the potential impact of diagnostic labels (Chen et al., 2020). The MHC model has been adopted widely as a tool to promote mental health in various settings and contexts in Canada and internationally (Chen et al., 2020; Franken et al., 2018). The mental health continuum short form [MHC-SF] has been validated in nonclinical samples and incorporated in various countries and cultures (Franken et al., 2018).

Social Workers and the Mental Health Continuum Model

An approach to practice that incorporates the MHC model can be helpful for social workers, regardless of practice setting. However, especially in rural, remote, and northern communities, this model can help social work practitioners to recognize specific behavioral patterns in clients that may need attention and allow them to suggest ways of dealing with service needs in creative ways. Creative approaches and out-of-the-box thinking can be helpful in settings that lack a comprehensive range of formal mental health supports.

For practicing social workers, this model can also offer helpful information to consider as they strive to maintain their own mental health and wellness by serving as a practical and reliable tool for social workers to identify their own sources of personal and professional stress by:

- Understanding how to identify symptoms of mental illness in oneself and others;
- Encouraging the growth and maintenance of a healthy mindset that can assist in overcoming distress and create positive movement on the continuum; and
- Learning how to deal with psychological and emotional crises effectively while not allowing one's well-being to be jeopardized (Chowdhury, 2021).

Generalist Social Work Practice in Mental Health Service Delivery

Undergraduate social work programs across Canada and North America focus on a generalist approach to social work practice (Weshues et al., 2001). This approach equips social workers with information on the basic concepts in social work, as well as a range of skills and a level of awareness that prepares them for a variety of social work roles in a range of settings. By focusing on generalist practice, students are introduced to ideas that include the promotion of well-being and the application of preventative and intervention methods to address social problems at individual (micro), group (mezzo), and community (macro) levels (Weshues et al., 2001). Although these levels are often spoken of as distinct, they actually occur in tandem and are linked to, and constantly influence, one another.

Rural, remote and northern locations offer unique opportunities for practicing social workers. In fact, many new social workers seek employment in these settings in order to gain practical experience in a relatively short period of time (Schmidt, 2008). Social workers in urban settings will tend to work in areas of practice considered to be more focused and specialized, whereas settings outside of urban areas require the social worker to engage in a number of areas of practice simultaneously. These areas of practice may include child protection services, addictions, mental health, income support, community development, and policy.

Mental Health Enablers and Barriers outside of Urban Settings

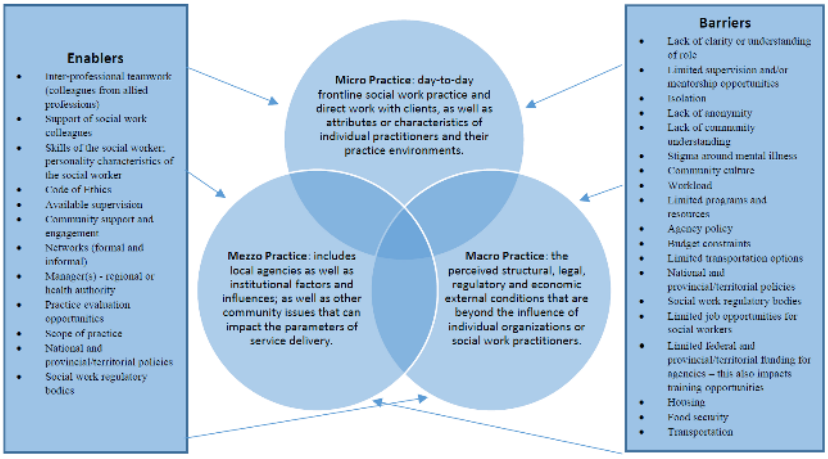
As discussed previously in this book, individuals who live outside of urban centres face unique factors that impact directly upon everyday life. While the quality of life in rural, remote and northern communities is idyllic in many ways, and is often sought after, the challenges associated with living outside of large centres can also affect that quality of life in negative ways – especially in relation to mental health. These negative effects include:

- Less comprehensive, available, and accessible support services,
- Transportation limitations due to geographic accessibility,
- Fragmented continuity of care,
- Difficulties with workforce recruitment and retention,
- Lack of access to affordable housing, and
- Limited access to population-based funding (CMHA Ontario, 2009).

In this context, a *barrier* to access is understood as any process or intervention by which access to mental health supports is impeded. *Enablers* are defined as any process or intervention by which access to mental health services and wellbeing is facilitated (Baxter et al., 2022; Lister et al., 2021). Figure 2 provides an overview of enablers and barriers to accessing mental health supports in rural, remote, and northern communities.

Figure 2

Enablers and Barriers to Mental Health Support Availability outside of Urban Settings



Note. This conceptual model shows the enablers and barriers to mental health support availability in rural and remote practice settings, and provides examples of micro-, mezzo- and macro-levels of practice that are impacted. The authors have created this figure based on their practice experience.

Rural, remote, and northern communities are not homogenous. The populations of people who live in these communities are diverse and represent distinct cultures, ethnicities, ages, and backgrounds. Despite this diversity, most individuals seeking supports and services for mental illness experience widespread stigma regardless of their backgrounds (Friesen, 2019; MacLeod et al., 2022).

Mental Health Issues and Stigma

The concept of *stigma* has been well-researched over the past 6 decades and has led to the conceptualization of stigma as a social construct. Dudley (2000) defined stigma as "stereotypes or negative views attributed to a person or groups of people when their characteristics or behaviors are viewed as different from, or inferior to, societal norms" (p. 449). These views may focus on what are seen to be mental, physical, or social deficiencies (CMHA Ontario, 2022). Stigma differs from discrimination, which is viewed as unfair treatment due to a person's identity. This identity can include race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability, including mental disorder (CMHA Ontario, 2022). In other words, stigma is the *negative stereotype*, and discrimination is the *behaviour* that results from this negative stereotype.

It is important to note that, because stigma is a social construct, it changes over time. What was stigmatized in the past may not be stigmatized today, or has changed in terms of how it is expressed at the micro-, mezzo- and macro-levels. This change often will occur as a shifting between the three levels. Goffman (1963) referred to this as the "process of devaluation" (p. 3), which can dehumanize anything or anyone that sits outside the lines of what the community believes to be acceptable. This process can create an "us versus them" scenario that is founded in difference, stereotypes, and misinformation; it can result in fear leading to unfair treatment of individuals. In a rural or remote community, this discrimination can be devastating, as an already small social network can become yet smaller, or even non-existent.

Stigma related to mental illness and mental health issues can have detrimental consequences. The World Health Organization [WHO] (2001) has suggested that stigma is one of the largest barriers to mental illness treatment engagement, despite the fact that treatment has been shown to be effective. Due to stigmatization, people may delay seeking help, may exit treatment prematurely, or may

completely avoid seeking services. These realities will often increase psychological distress and when individuals can no longer wait due to an increase in symptoms, the level of distress is significantly greater. Stigma can impact social activities for individuals experiencing mental illness, along with education, housing, and employment; the result is often social isolation. Herek (2002) stated: "stigma and discrimination are the enemies of public health" (p. 604). Stigma in the rural and remote areas of Canada can be further compromised by a shortage of services in the areas of mental health and addictions, and difficulty in accessing those services. Stigma at the micro-, mezzo- and macro-levels, in conjunction with a lack of formal supports, can leave people in a very precarious position.

Social workers work with a variety of complex cases that require a thoughtful approach. Working in rural and remote areas with under-served populations requires the social worker to have a sophisticated level of knowledge and understanding of mental health and mental illness, as well as ethical fortitude. Further, a knowledge base of the current and historical culture of the geographic region in which they are practicing is critically important. No two communities are the same and each will have distinct enablers and protective factors, as well as specific barriers and factors that may put people at greater risk. An insular community may have a variety of protective and enabling factors, but someone who is marginalized within that community may also feel like an outsider. This experience will undoubtedly affect that individual's mental health. Social workers working in rural and remote communities have a unique opportunity to influence efforts to de-stigmatize mental illness. They will work with individuals and their families and can mitigate stigma at the micro- and mezzo-levels. For example, involving the family will support the individual with mental illness, and help the family to understand conditions impacting mental health; this can re-build the family structure and support system. On a macro-level, the social worker will have opportunities to support educational efforts to de-stigmatize mental illness and advocate for local and regional changes. They can advocate for policy change, and ensure that mental health policy is being developed at the same time and rate as health policy. Through the nature of their generalist practice approaches, social workers will also be networking with various agencies and can be an agent of change to support community-wide mental health and wellness initiatives.

A social worker working in mental health services requires the ability to self-reflect about their own stereotypes, beliefs and prejudices. It is also important to acknowledge that we, the community in which we serve, as well as the person in need; all have known and unknown attitudes about what they are coming to discuss. We must create a space where these attitudes and beliefs can be explored and tested, in order to determine their impact on services.

Areas of Practice in Mental Health Services

As discussed throughout this book, a social worker engaging in practice outside of urban settings will have many opportunities to work with a range of individuals from diverse backgrounds. These individuals will seek support services from social workers in order to deal with many aspects of mental health and mental illness. This section will focus on five select areas of social work practice specific to mental health in rural and remote settings: suicide prevention and intervention, substance use and addictions, chronic mental illness, maternal mental health, and violence.

Suicide Prevention and Intervention

In Canada, suicide is identified as the ninth leading cause of death among the general population. However, for individuals between the ages of 15 and 34, suicide is the second leading cause of death (MHCC, 2022b). In first world countries, men are three times more likely than women to die by suicide (WHO, 2017). Lesbian, gay, bisexual, transgender, queer/questioning and other sexual and gender minority (2SLGBTQ+) youth have also been consistently identified as having an elevated risk for suicide (Wang et al., 2021).

The Mental Health Commission of Canada (2022b) reports that alcohol abuse is the second most common mental health problem identified in people who die by suicide, and one in four deaths by suicide are completed by those who abused alcohol. Suicide rates are also higher in rural areas as compared to urban areas (Creighton et al., 2017; Frederick, 2020; Reccord et al., 2021). The rates of suicide in Canada are consistent with suicide rates in other first world countries that experience similarities in terms of poverty levels, aging populations, lack of employment opportunities, and out-migration to urban centres (Cleary, 2012).

Suicide has had a profound impact on communities that are predominantly First Nations, Métis and Inuit. In fact, the suicide rates among First Nations and Métis adults have been reported to be twice as high as among non-Indigenous adults (Park et al., 2015). The rates of suicide in Northern Saskatchewan are very high, and suicide is identified as the leading cause of death for people aged between 10 years to 40 years (Irvine & Quinn, 2017). Suicide intervention approaches need to be culturally responsive in areas that have a higher First Nation, Métis and Inuit population; where the impacts of colonization and inter-generational trauma are the predominant underlying factors impacting suicide rates.

Suicide prevention strategies should be targeted to the local demographics and culture in rural and remote communities, and designed by local stakeholders with a focus on community needs and assets. Social workers can play an important role in suicide prevention, education, and intervention.

Suicide in in rural and remote areas is of significant concern, yet populations impacted by suicide continue to be overlooked and underserved at all three levels of intervention (micro, mezzo, and macro). A review of the literature by Hirsch and Cukrowicz (2014) identified that successful interventions require a thoughtful approach which focuses on the geographic location, social belief systems, and determinants of health that impact suicide. It is also important to recognize the effects of poverty and lack of employment opportunities, as well as the importance of creating literacy around mental wellness and building trauma-informed communities.

As social workers, we have to pay attention to social, cultural, and economic-specific strengths and adversities of communities, as well as social and cultural norms. Every rural or remote community will have its own nuances about what is stigmatizing, its own history within Canada, and its own trauma legacy.

Substance Use and Addictions

Addictions can affect anyone. The Canadian Mental Health Association estimates that approximately 21% of the Canadian population (about 6 million people) will meet the criteria for addiction at some point in their lifetime (CMHA, 2022). Alcohol is identified as the most common drug used by Canadians, and those living in rural and remote areas of the country were more likely to report heavy drinking compared to those living in urban areas (CCSA, 2019; Statistics Canada, 2019).

The American Society of Addiction Medicine (2019) defines addiction as "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences". The topic of addictions is vast as it includes the abuse of illegal substances, the misuse of legal substances, as well as compulsive behaviors involving gambling, internet/gaming, and sex. As social workers, it is important to be aware of language and how that language is used in this area of practice. In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders [DSM-5] (APA, 2021), revisions were made to include *Substance-Related and Addictive Disorders* with substantive changes to the disorders grouped there, plus changes to the criteria of certain conditions. The DSM-5 explains that the essential feature of a substance use disorder is that it includes a cluster of cognitive, behavioral, and physiological symptoms highlighting that with this disorder, the individual continues using the substance despite significant substance-related problems (APA, 2021). In other words, people with *addictions* use substances or engage in behaviors that become compulsive and often continue the behaviors despite harmful consequences.

Understanding the complexity of addiction is essential for social workers and those working to support individuals with addictions; Gabor Mate (2011) explains that addiction is more than a disease or human choice, it is a response to human suffering. Using substances may provide the person temporary relief from emotional and physical pain, however it can exacerbate the problem and have harmful impacts on one's health, relationships, work/responsibilities, finances, and may lead to legal problems.

The misuse of alcohol and drugs is influenced by individual, cultural and social factors which can serve as protective and/or risk factors (enablers and barriers). These factors need to be considered when working with individuals and families as part of preventative programming, intervention/treatments and rehabilitation processes. For social workers working in rural and remote areas with people and communities experiencing addiction, consideration of these factors is essential to the working relationship and change process. First, the rural and remote location must be acknowledged and considered, as these places throughout Canada do not have the same access and availability of services as do urban centres. This can be challenging for individuals and families experiencing concerns with mental health and substance use as it may require additional time and financial resources in order to connect with supports; all which can further complicate one's physical, social and mental wellbeing.

Telehealth services and online programming are often options that can be beneficial for individuals and families living in rural and remote communities, as these options create possibilities for people to connect with informal and formal supports in order to address physical health concerns, as well as mental health concerns. An example of services being utilized in this way can be found in remotely delivered Alcoholics Anonymous or Narcotics Anonymous group meetings. Online meetings allow people more options to attend virtual gatherings that support their schedule, can reduce the need to travel long distances, and also can provide greater anonymity. Although this modality of service may increase accessibility for some, it is not always possible for others as this approach requires internet access, computer literacy skills and a safe and quiet space to connect. Understanding how these factors can be barriers is essential to the helping process.

Individuals misusing substances can be at different stages in their use and readiness for change. A harm reduction approach includes strategies to reduce individual harm through managed consumption and overdose prevention sites. This approach, which was initially developed in the 1980s, recognizes the individual and meets them "where they are at" to help reduce harm, address basic needs, and increase safety and wellness. This approach to service delivery also increases engagement of clients, and supports willingness to change. Harm reduction and social work share common values and approaches, not the least of which is recognizing the client (service-user) as expert, and using strengths-based efforts to build collaborative working alliances (Vakharia & Little, 2017).

Navigating the system to help support individuals with substance use disorders can be especially challenging in rural and remote locations, due to limited outpatient and inpatient services and waitlists. It is important for social workers to understand how social and health determinants contribute to risk, to the treatment of substance misuse, as well as overall wellbeing.

As discussed earlier, individuals living in rural and northern locations report high levels of excessive use of alcohol. Higher rates of driving while impaired is also common. In recent years, opioid use has emerged as a crisis across Canada, and this issue is especially difficult to address in rural and northern communities. These two types of addictions will be discussed further below, as will the issue of impaired driving.

Alcohol

Accessibility and availability of resources for alcohol abuse prevention, intervention and recovery are influenced by social and cultural factors. Poor socio-economic conditions found in many rural communities is correlated with higher levels of alcohol consumption, psychosocial stress, and decreased physical activity and preventive service use (Smith et al., 2019). The limited resources available create an additional challenge when trying to arrange services that are appropriate and meet the individual's needs. Rural physicians show an awareness and concern for alcohol consumption in their communities, but they also report difficulties in accessing resources to refer patients for substance use treatment (Slaunwhite & MacDonald, 2015).

Communities with smaller populations and/or communities that are located in isolated areas can create more familiarity for individuals. This factor can be understood as both an enabler and as a barrier when it comes to seeking support services. Familiarity may bring people a sense of belonging and support, yet it can also be isolating for those who don't fit the identified community norms and expectations. The lack of anonymity can prevent individuals and families from seeking help due to shame and stigma. Stigma continues to be a factor that potentially isolates people experiencing difficulties with substance use.

It may be helpful for social workers to consider a social-ecological perspective for explaining influences on alcohol use. Individual-level factors that influence alcohol use are found within home, work, and school environments, which are located within the larger community. Macro-level factors, such as exposure to advertising, may influence family and peer network attitudes and norms, which ultimately impact individual attitudes and behaviors. Social work focuses on the person within their environment and recognizes the importance of family, community, culture, legal, social, spiritual, and economic influences that impact well-being of individuals, families, groups, and communities.

Opioids

There is an opioid crisis affecting communities across Canada (Pijl et al., 2022). This crisis is affecting individuals, families, and communities, often resulting in long term health issues like HIV and hepatitis, possible overdose, and death.

Jones and Quinn (2021) illustrate the impact of remote geography on clinical decisions, adequate medication supply, and the importance of engaging pharmacy and nursing colleagues in delivering addictions care specific to the use of opioids. National practice guidelines for opioid use disorder recommend buprenorphine–naloxone as a first-line treatment. In rural areas, medications that can be administered on a monthly basis, like buprenorphine and/or naltrexone formulations, might be particularly effective since distance and transportation can present barriers to daily-dose treatment approaches (NIDA, 2021). Clinical practice guidelines state that methadone maintenance therapy (MMT) is the standard of care for treating patients with opioid dependence. Methadone maintenance therapy is a substitution/maintenance treatment model whereby methadone is administered in a structured treatment environment to reduce or eliminate the uncontrolled use of illicit opioids (NIDA, 2021).

Impaired Driving

Research has shown that rates of impaired driving tend to be about twice as high in rural areas as compared to urban areas (Perreault, 2019). For the purpose of this discussion, impaired driving refers to driving while under the influence of alcohol, cannabis, or other mind-altering substances. Greene et al. (2018) found that these rates were often higher in younger age groups and identified specific factors that contribute to those higher rates: social context (peer pressure and parental modeling), rural cultural values (independence, stoicism, and social cohesion), as well as the realities of the legal and physical environment (minimal police presence, sparse population, and no alternative transportation). Since 2018 when Canada became the second country to legalize non-medical cannabis, emerging research has confirmed that driving under the influence of cannabis is an increasingly prevalent road safety issue (Brands et al., 2021). As discussed earlier, higher rates of cannabis and alcohol use are also linked to increased suicidal ideation in young people. Suicidal ideation, or suicidal thoughts, means having thoughts or ideas about the possibility of ending one's own life.

Social workers practicing outside of large urban centres play a key role in working with individuals with substance use and co-occurring disorders, as well as their families and communities. As such, knowledge about substances, behavioral indicators of substance use, relevant assessment tools, and knowledge about available and accessible treatment and support options is essential.

Chronic Mental Illness

Long-term and chronic mental illness is multi-faceted and complex, requiring a coordination of support and collaboration at all three levels of social work practice (micro, mezzo and macro) beginning when the individual seeks ongoing support, and continuing as they enter into the recovery and long-term support process. Most often in the literature, those with chronic mental illness are identified as individuals with Serious Mental Illness (SMI) (Steele et al., 2014), and this is the term that will be used in this discussion. Individuals with SMI fall at the extreme right side of the mental health continuum and may require a greater level of tertiary care in order to stabilize their mental illness and avoid further deterioration. Those with SMI usually require long-term medication and support, and this can include schizophrenia and schizophrenic-like disorders, but can also refer to any reoccurring mental illness that produces serious functional impairment and interferes with the person's quality of life including psychosis and bipolar disorders (Steele et al., 2014). Individuals with SMI typically experience gaps in services and these gaps are more pronounced in rural and remote locations that lack community resources and in-patient capacity.

Individuals with SMI tend to socially isolate themselves and this can have compounding effects on the course of their recovery. A supportive and resourced community can have significant and positive influence on the lives of people living with SMI. Protective factors increase when the social capital of the community is more robust. Social capital includes friends, social norms, networks of support and employment opportunities for the individual with Serious Mental Illness in the community (Dykxhoorn et al., 2019), and can play an important role in the person's overall mental health and physical wellbeing. Social capital also includes the infrastructure of a community such as parks, libraries and other pro-social activities like volunteering opportunities. In their research, Kitchen et al. (2012) found a very strong association between health (mental health in particular) and a sense of belonging, especially in rural areas of Canada.

Peer support can have a positive impact on the person with SMI, as well as the family who may struggle with their own perceptions of mental illness. Peer support can include group activities, mentoring, and a system of mutual giving and receiving where individuals with SMI can offer hope, companionship, and encouragement to others facing similar challenges (Naslund et al., 2014). Peer support lays primarily in the mezzo-level of support provided by social workers, and can have a significant impact on the micro-level as the social capital increases and the person's sense of inclusion and community belonging also increase. Individuals with SMI often turn to social media to seek information and create communities to share their experience, and to obtain information from others with a similar diagnosis. This network building can significantly reduce personal and social stigma and normalize experiences as they increase insight about their diagnosis, develop on online community where potentially none exists in their home community, and gain support from others in similar circumstances including gender, age, culture and other demographics that may be important to the individual. However, vulnerability is a potential risk that needs to be considered when entering the online platform.

Individuals with Serious Mental Illness represent 30% to 40% of the homeless population and as many as 25% of those same individuals have a substance dependence (Kirby & Keon, 2006). Although rural and remote homelessness in Canada remains a hidden issue, there is mounting evidence that homelessness is as prevalent in rural communities as it is in urban settings (NAERRH, 2021). As the individual with SMI moves between recovery and maintenance, the importance of housing in the stabilization of psychiatric symptoms is highlighted as a significant factor in their recovery. Stable housing is especially important for social workers to keep in mind when working in rural and remote locations where the interplay between the mezzo- and macro-levels can have a significant impact on the quality of life of the individual. This issue highlights the importance of developing a coordinated and collaborative approach encompassing all three levels of support and intervention (micro, mezzo, and macro). Social workers can provide individual support, as well as sessions for couples and families. The role of social workers in working with individuals with SMI

also includes conducting psychosocial, cognitive and mental health assessments, and working as part of an interdisciplinary team to develop and support individualized treatment plans. As social workers, our work *helps to reduce stigma and promote evidence-based treatment for all* persons in need of support. This support may include advocacy work at the mezzo- and macro-levels to address some of the basic human needs of individuals with SMI at the municipal, provincial, and federal levels.

Maternal Mental Health

Having a baby can be an exciting and life affirming experience; however, this is not the experience of all families. The perinatal period is often an overwhelming, stressful and anxiety-inducing time that can affect every aspect of life for the woman, partner and family unit. As a social worker, working in rural and remote locations with families during the perinatal period is recognized as practice that is potentially impacted by great risk, as well as opportunity for the greatest outcomes.

In Canada, one family experiencing PMADs (Perinatal mood and anxiety disorders) is estimated to cost the healthcare system over $150,000. However, by utilizing a simple screening tool and providing access to treatment, the cost is estimated at $5000 (Bauer et al., 2014). As social workers, we also consider the hidden costs that include the impact on the child, mother, family and community. Suicide is the leading cause of death during the perinatal period for women (Bauer et al., 2014; Grigoriadis et al., 2017).

Maternal mental health is defined as “a state of well-being in which a mother realizes her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her community” (McCauley et al., 2019, p. 2). The term perinatal refers to the period of conception up to and including 12 months after a birth. Perinatal mood and anxiety disorders (PMADs) refer to a variety of mental health issues that fall within the mental health continuum. They include Depression, Bipolar Disorder, Anxiety, Panic Disorder and Obsessive-Compulsive Disorder. In extreme situations, Psychosis can also be included, but this would be classified as a rare medical emergency.

Understanding perinatal mood and anxiety disorders (PMADs) and their origins is as complicated and unique as is the woman and family unit. As a social worker working with new or expecting families, you need to familiarize yourself with the signs and symptoms of PMADs. Risk factors increase or decrease depending on a number of factors that may include social, psychological, environmental, and hormonal issues. Families that are marginalized and experience lower socio-economic status, food insecurity, family violence, adverse life experiences, historical trauma, and are 2SLGBTQ+, are at increased risk of developing PMADs. First Nations women are 20% more likely to have post-partum depression than Caucasian women (Dharma et al., 2019). It’s important to note that not all families who share these particular factors are destined to have PMADs. However, every family is at risk of developing PMADs; for instance, even fathers/partners may experience symptoms of depression after the birth of the baby at a rate of 10% (Paulson & Bazemore, 2010).

The short- and long-term consequences of untreated perinatal mood and anxiety disorders (PMADs) can be detrimental to the woman, baby, family and community. Depression and anxiety can present distinctly for each woman, though some common features include feelings of sadness, lethargy, anger and worry. These are unlike “baby blues” that are shorter in duration and lack physical and emotional intensity. Other outcomes include impact on the partner relationship, attachment issues, as well as social, emotional and cognitive development in the baby (Letourneau et al. 2012).

When reviewing how Canada is doing with respect to maternal mental health (Hippman et al., 2022), research identified numerous gaps and regional differences, and advocates for a national perinatal mental health strategy that would target prevention and triaging into treatment and support. From a social work perspective, this advocacy work is best coordinated at all three service levels (micro, mezzo, and macro).

Parents residing in rural and remote locations are often burdened with travel costs and face the reality of having to leave their other children behind to be tended to by members of the community when they have to access labor and delivery services in larger urban centres. Some rural and remote locations may have a health centre, but due to physician shortages and the lack of locum doctors, families may be directed to another community to access care. Parents experiencing high risk pregnancies are usually directed to leave their home community at 38 weeks gestation or earlier, which can create financial barriers requiring travel and a hotel stay; the parent would then also be in an unfamiliar community without any informal supports (family and friends) to rely upon.

Building maternal mental health capacity in rural and remote locations requires a multi-faceted approach that considers the local culture, community strengths, and opportunities for development. Many remote communities have a long history of childbirth and mental wellness, and each geographic area will have its own ceremonies, traditions and protocols that honour the significance of taking care of the family in a holistic manner. The use and training of doulas and midwives who are connected to the community would be an example of building capacity at the community level, as would training of maternal mental health providers (including social workers) in a manner that is respectful of the traditions and culture of the region. Key social work competencies when working with families during the perinatal period include:

- Treating the family with respect, and honouring their specific cultural needs and requests;
- Providing education on positive mental health and appropriate screening tools;
- Sharing knowledge of both formal and informal supports available in the community to support the family unit; and
- Enhancing the attachment between baby and caregivers.

Violence

Social workers engage with vulnerable populations that are experiencing various challenges, and this includes working with survivors and perpetrators of violence. Regardless of the geographic setting, violence is a multifaceted issue and it has detrimental effects on the individual, family and community. In providing mental health supports, prevention initiatives and intervention services must consider individual, community, and societal factors and how they affect individuals and families experiencing violence. Social workers work collaboratively to initiate life-changing interventions and support mental health on a daily basis, and in rural and remote communities there is always the potential for social workers to find themselves alone in a dangerous situation during such interventions.

The World Health Organization Violence Prevention Alliance divides violence into three sub-types according to the victim-perpetrator relationship: self-directed violence (suicide, suicide attempts and self-abuse), interpersonal violence (youth violence, intimate partner violence, sexual violence, gender-based violence, child maltreatment, and elder abuse), and collective violence (violence committed by larger groups of individuals and can be subdivided into social, political and economic violence) (WHO, 2010). The World Health Organization (2010) also states that violence represents a “major health, criminal justice, human rights, and development challenge” (p. 2). It over-burdens health and mental health systems, undermines communities, and slows economic and social development (WHO, 2010).

Regardless of the type of violence that is impacting communities and mental health, social workers need to be familiar with risk assessment, risk management and safety planning. Conducting a thorough risk assessment of every client is critical, and should always include efforts to determine a prior history of violence, mental illness or other mental health-related challenges, drug and alcohol use, and weapon use. There is no doubt that information and knowledge is powerful when trying to prevent violence, and to mitigate the effects of violence.

When working in remote and rural areas, it is important to build relationships and understand the uniqueness of the community. This includes building knowledge of available resources and programs to support good mental health, and understanding cultural norms that can serve as risk factors or protective factors. Rural and remote communities do not have access to the same formal mental health supports and services as do urban centres.

Geographic isolation can contribute to barriers for those seeking services, such as a lack of transportation and limited access to appropriate resources. Other challenges for individuals who have experienced mental illness, addictions, and violence living in rural and remote areas include greater distances between homes, being less visible to neighbors or other potential witnesses, and being further away from emergency services. In many rural and remote areas there are an abundance of weapons, as well as situations where the justice system allows the return of weapons for hunting season to those charged and convicted with violent offences. Access to e-mail and the Internet, as well as adequate and consistent cell phone coverage, is not available in many areas outside of large urban centres (Kasdorff & Erb, 2010).

Rural communities have unique resources and capacities for mental health resilience such as a tightly knit network of support and a strong relationship to the natural environment (Hirsch & Cukrowicz, 2014). These can be protective factors when one fits in, and they can create a sense of belonging within close, tight-knit communities. However, these same unique resources and capacities can also contribute to a heightened risk of conflict and violence.

As a social worker delivering mental health services in areas outside of large urban centres, you will need to take proactive steps to mitigate violent encounters. First, all practicing social workers must have adequate and responsible supervision and support from a supervisor. This supervision should support ethical considerations and best practice, while instilling a culture of safety and risk reduction. Secondly, social workers should have access to relevant safety training and technology, including GPS tracking. In recent years, there have emerged a number of innovations in mental

health service delivery that have the potential to be particularly helpful in rural, remote, and northern environments by creating safe options for clients and social workers outside of large urban settings.

Innovations in Mental Health Service Delivery

Telehealth is an innovation that originally emerged to help bridge the distance for residents living in rural and remote areas in order to access health care. Telehealth is defined as the use of digital information and communication technologies, such as computers and mobile devices, to access personal health care services remotely (Mayo Clinic, 2022). More specific to mental health interventions, telepsychiatry facilitates staff education and specialty consultation; reduces rural practitioners' sense of isolation; better protects patient anonymity, potentially reduces stigma; generates reliable diagnoses; and yields high patient and provider satisfaction (Hubley et al., 2016).

In addition to more traditional telepsychiatry services, there are other options that have emerged in response to limited accessibility and resources such as telephone helplines, telephone counselling, video counselling, Internet Cognitive Behavioral Therapy (ICBT), walk-in (rapid access) counselling services, mobile apps, and other digital health platforms. The next sections will focus on mobile apps and digital health platforms, as well as walk-in counselling (rapid access) service options.

Mobile Apps and Digital Mental Health Platforms

Mental wellness/health apps and digital mental health platforms have continued to increase in popularity, and are seeing further development and growth as users download them with the hopes of managing and addressing mental health challenges and mental illness such as anxiety and depression (Marshall et al., 2020). Increasingly, governments and service providers are endorsing these options as viable alternatives to face-to-face support due to low cost, convenience, and accessibility (Parker et al., 2019). A number of treatment approaches including cognitive behaviour therapy (CBT), dialectical behaviour therapy (DBT), and prolonged exposure therapy are being assimilated into apps that can stand alone or supplement the face-to-face therapy process (East & Havard 2015).

Mental health apps and digital platforms have the potential to reach people who would otherwise not receive help by removing the barriers to access. These apps and digital platforms may reduce cost, eliminate wait-times, and may also reduce the stigma that can exist for those receiving support for mental health challenges. These support options can promote user autonomy by facilitating self-awareness and self-efficacy, which fits within the realm of social work values. For those outside of large urban centres, mental health apps may also be applied for real-time monitoring of users who are in crisis without available in-person supports (Robillard et al., 2019). Barriers to accessibility of mental health apps and digital platforms, however, exist due to connectivity issues in rural and remote locations, computer and technological literacy issues, as well as costs associated with the purchase of cell phones and computers. There is also a cost associated with accessing the apps themselves.

A lack of privacy can also pose challenges for some who do not have a private place to talk due to others in the home and/or concerns around safety. For some individuals, seeking help can risk their safety and wellbeing. As a result, there are some mental health websites and apps that have a quick exit feature to increase safety for people at risk of, or are experiencing, violence.

Finally, because there are no regulations nor standards in place for mental health apps and digital platforms, they may provide inaccurate information and resources and services that are not evidence-based; which poses ethical concerns from a social work perspective. However, these options continue to be developed and made widely available. The research and literature regarding efficacy of these approaches to support mental health and wellness is limited, but data suggests that this technology is being well-utilized by subscribed users (Marshall et al., 2020; Robillard et al., 2019).

Walk in Counselling (Rapid Access)

Walk in counselling clinics have been operating throughout Canada for over 25 years, and this approach to service delivery is more established in Canada than anywhere else in the world (Hoyt & Talmon, 2014). The rapid access model of counselling is typically implemented to help reduce barriers for individuals seeking support and as a response to diminishing resources (Harper-Jaques & Foucault, 2014). Within rural and remote communities, few affordable counselling services are often available, which can result in people not receiving help when they are seeking it. Again, this may be due to factors such as lack of transportation, length of travel time, lack of child care and/or the stigma related to seeking help. Walk in counselling services have emerged as a creative means to reduce barriers and offer individuals and families help when they need it.

Conclusion

Accessibility is one of the five pillars of the Canada Health Act (Health Canada, 2015), yet many Canadians continue to experience barriers to accessing the care that they need. This is especially true for individuals living in rural, remote, and northern areas in Canada who are seeking mental health supports and treatment options for mental illness. As service providers living and practicing in these communities outside of large urban centres, social workers are well-positioned to provide information, assessments, interventions and ongoing supports to individuals struggling with mental illness and addictions.

This chapter discussed mental health and mental illness, with a particular emphasis on the mental health continuum [MHC] model as a tool to be utilized by social workers in rural and remote settings. An exploration of enablers and barriers to accessing mental health supports was provided, and select mental health issues and challenges that social workers address in rural and remote settings was examined. In particular, suicide prevention and intervention, substance use and addictions, chronic mental illness, maternal mental health, and violence were discussed.

There continues to be stigma associated with mental illness and for those experiencing issues with their mental health. The Mental Health Commission of Canada reports that one in every five Canadians experiences a challenge to their mental health within a given year (MHCC, 2022a). While we often have a good understanding of physical illness, there tends to be less knowledge available about mental illness or substance use issues. As discussed in this chapter, a lack of understanding leads to fear and negative attitudes towards individuals living with mental illness and addictions, and it prevents people from seeking help for themselves and from providing appropriate support to people around them. These issues are even more apparent in rural and remote communities.

Just as social workers provide information, supports, and care to those in rural and remote communities who struggle with challenges to their mental health; social workers who practice in rural and remote settings must also work to maintain their own mental health and wellness. Having the support of colleagues and supervisors can be essential to avoiding burnout for any social worker. However, social workers practicing outside of large urban centres often do not find those connections easy to build. As a result, they must create supportive networks with allied professionals and social workers in different regions in order to access the feedback and collaboration that is needed for their own mental health and wellness. Maintaining good mental health is essential for good social work practice.

Nuelle Novik (pronoun she/her), a white settler who grew up in rural Saskatchewan, has lived and practiced social work in rural, remote, and urban settings. I acknowledge that my positionality grants me inherent privilege and influences the way in which I interpret the world around me.

Brent H. McKee Pronoun (He/Him); White Settler: Brent has been practicing as a Registered Social Worker in Saskatchewan within the field of mental health for over 30 years. His practice is specialized in maternal mental health and is rooted in trauma-informed practices, attachment theory and systems theory. Anti-oppressive and person-centred practices with a strong underpinning in the social determinants of health is the foundation of his work. Social work plays a pivotal role in supporting individuals, families and communities at all levels of interaction.

Karmen Pearce is a White/Caucasian female who grew up in rural Saskatchewan. She currently resides in Yorkton, SK and is employed as a Registered Social Worker.

Activities and Assignments

- Think about the various stereotypes that you have heard about people experiencing mental illness over your lifetime. Have those stereotypes changed over the years? Which of those stereotypes do you believe are still prevalent for you, or for your family, or in your community? How might these stereotypes affect you as a social worker supporting individuals and families living with mental illness in rural or remote communities?
- What are some of the barriers that individuals seeking help in order to address suicidal thoughts in rural and remote locations might encounter? What are some of the enablers that might support a suicidal individual in seeking mental health support?
- Online peer support can be beneficial for the person with serious mental illness (SMI) living outside of an urban centre. As the social worker supporting this individual utilizing online peer support, what factors would you need to consider to mitigate potential risk to the individual?

- Identify a rural or northern community that you are familiar with, and list the services that are available there to support maternal mental health. What barriers to good mental health for a family with a newborn might be present in that same community?

Additional Resources

- Mental Health Commission of Canada [MHCC]. (2021). *Answering the call: Strategic plan 2021/2030*. Available on the Mental Health Commission of Canada website.

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Supplementary Material

1

PowerPoint for the chapters listed below available as additional instructor resources:

Chapter 2 – Place in Anti-Oppressive Practice Rurality Decolonization and Equity
Chapter 4 – Practice Competencies to Effectively Support Wellness for Social Workers and Clients in Northern Saskatchewan Communities
Chapter 5 – Anti-Oppressive Practice in Rural Small Indigenous Communities
Chapter 6 – Braiding Trauma-and-Violence Informed Care Practice Guidelines into Competencies for Social Workers
Chapter 7 – Sustaining Our Own Mental Wellness
Chapter 8 – Informed Approach to Disclosures of Abuse and Healing
Chapter 9 – Social Work Practice and Mental Health Services Outside of Urban Settings
Chapter 10 – Understanding and Supporting Immigrants and New International Arrivants in Rural and Northern Communities
Chapter 12 – Older Adults in Rural Communities
Chapter 13 – Child Protection in a Rural Setting

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Sustaining our Own Mental Wellness: Burnout, Vicarious Trauma, and Compassion Fatigue in a Rural Context

7

Melanie Abbott

Social work is a remarkable profession with many possibilities. The contexts in which we work, the changes we can help to effect, the individuals whose lives we have the opportunity to touch, are vast. But along with this wealth of possibilities comes some challenges including the mental health toll it can take. Hearing people's traumatic stories, not having the appropriate resources to refer to, or being held back by organizational structures can all play a role in challenging even the strongest of our coping skills. Just because we may have, and even teach, the tools that can help maintain mental wellness does not mean we are immune to experiencing the effects ourselves. Not maintaining our own mental wellness can have far-reaching consequences including physical repercussions, damage to relationships, and even loss of employment. It is not just who we work with, however, that contributes to the impact the work can have on us. Location also matters. Working in rural and remote locations brings a different set of challenges as well as advantages from urban settings.

We know that the helping professions can be stressful. There is unpredictability requiring personal and contextual judgement rather than simplistic or formulaic solutions. We are also exposed to situations that the lay-person is not, seeing a side of humanity that not everyone does. Stress taps into our personal coping abilities and sometimes impacts our mental and physical health and relationships; however, stress is also temporary, and tends to increase or decrease in particular circumstances. Stress is sometimes just the tip of the proverbial iceberg when it comes to the mental health challenges social workers can face, meaning that it may be managed by doing, for example, self-care, engaging in social activities, meditating, and setting boundaries when it comes to workload. But sometimes it goes beyond "regular" stress and escalates to the point of interfering on a deeper level which can start to cause lasting changes in us. The causes of the mental health challenges we may experience professionally can come from job-related and client-related factors, which will be the focus of this chapter. For job-related factors we look at burnout; for client-related factors—how we respond to the trauma of others—we look at secondary trauma/secondary traumatic stress, vicarious trauma, compassion fatigue, and empathic strain.

When you hear the term "burnout," what comes to mind? This often has a certain image connected to it: a person who is irritable, perhaps calling in sick more often, or snapping at someone who talks to them. The image is often of a person with piles of paperwork on their desk, perhaps coming in early or staying late, but still not catching up on their work. Now what about secondary trauma? What comes to mind when you read this term? The image might not be as clear, particularly to those who have not experienced it. If we focus on the word "trauma," some of those symptoms might come to mind: jumpy, emotionally labile, poor sleep. How is this similar or different in a person who experiences the trauma first-hand (primary trauma) and the helping provider who experiences it second-hand? These experiences will be the focus of this chapter: how social workers are impacted by the work we do, both by the impacts of the job itself and the organization we work for, as well as how we cope with the trauma of others. Although many distinct terms are used to identify the nature of the mental health impacts this line of work has on individuals, for the purposes of simplicity and understanding, in this chapter we will focus on three: burnout, compassion fatigue, and vicarious trauma. The case examples provided to illustrate some topics are all fictional, but some are loosely-based on the author's personal experiences, or composites of several social workers the author knows.

Learning Objectives

By the end of this chapter you will have had the opportunity to:

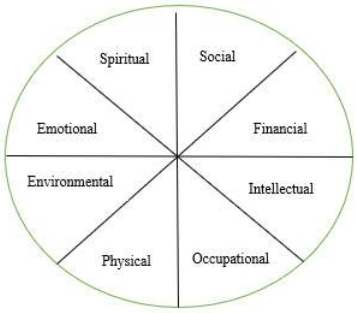
- Learn about the concepts of burnout, compassion fatigue, and vicarious trauma.
- Explore some of the unique challenges of living and working in rural and remote locations.
- Understand why location matters by exploring some of the unique factors contributing to mental wellness or un-wellness among social workers in rural and remote settings versus urban ones.
- Recognize some ways that we, as social workers, can mitigate some of the above symptoms and promote our own mental wellness so we can be present with our clients, but also have an improved quality of life outside work.

Burnout, Compassion Fatigue, and Vicarious Trauma

As social workers, we know (logically) that individuals need to have balance to be healthy. Consider a wellness wheel (Figure 1) which depicts where we direct our energies.

Figure 1

Example of a Wellness Wheel



If we put more focus in one or two areas and very little in others, our wheel will not roll very smoothly. If we are not careful, we may start to put more energy into work and our clients than we are putting into our personal lives, leaving our wheel unbalanced. Whether the overload is coming from job- or client-related factors, the impact on us will look different.

Let us now explore some definitions to put this idea of mental health of social workers into context.

Burnout

Burnout relates to organizational factors as opposed to the effects of working with a particular clientele. These are often connected to our lack of ability to effect change due to organizational limitations. Burnout is defined as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed" as per the World Health Organization's (WHO) International Classification of Diseases (ICD-11 as cited in WHO, 2019, para. 4). Maslach and Leiter (1997), pioneers in the research on burnout, conceptualized a multi-dimensional approach to burnout with six factors being contributors, although only one needs to exist to cause it. These six factors are workload demands, lack of control or autonomy over one's work, lack of positive feedback or recognition for a job well-done, the workplace community (how much we can count on our colleagues to support us, how much trust we have in each other, social connections), fairness with respect to opportunity (for promotions and training, for example), and consistency of our work with our personal and professional values. According to these same researchers, burnout presents itself in three overarching symptom clusters, or dimensions: exhaustion, cynicism, and ineffectiveness. Exhaustion is more than just being tired, and is reflected in a complete lack of energy, both physical and mental, going to bed tired, and waking up tired. Cynicism, later termed depersonalization, is having a negative attitude to one's job or career, which causes one to detach from it mentally, not believing in the work or one's ability to effect change. Finally, ineffectiveness relates to the inadequacy one feels about their work and their ability to do their job, causing lack of productivity.

Maslach played a very important role by acknowledging the phenomenon of negative impact on individuals in the helping professions. She initiated a discussion of burnout in the 1980s and created the MBI (Maslach Burnout Inventory) to help assess for it (Maslach et al., 1996). Since the early days of burnout research and development, researchers have continued to explore the topic and challenge some of the concepts. For example, some newer research is questioning whether burnout is related to a depressive disorder rather than its own entity, since many of the symptoms overlap (Bianchi et al., 2020), where others have posed whether burnout may be more closely connected to post-traumatic stress disorder or anxiety disorders (Simionato & Simpson, 2018). The primary distinction seems to be that burnout symptoms have resulted from the job context as opposed to other life events. Currently, burnout is not its own diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), but the symptoms may be seen in other diagnoses, as identified above. It is, however, included in the World Health Organization's International Classification of Diseases (WHO, 2019), which looks at all diseases, not only mental illness. In this diagnostic system, burnout is seen not as a medical or mental health condition, but as an occupational phenomenon. The way the ICD-10 is organized, the letter at the beginning of the code signifies the category of illness, and then letters and/or numbers follow providing

more clarity. For example, “F” relates to “Mental, Behavioral and Neurodevelopmental Disorders,” and this where one would find depressive and anxiety disorders. Burnout is not included in the “F” category at all. Instead, it is in the “Z” section, which is “Factors Influencing Health Status and Contact with Health Services.” It is further defined under a sub-heading (Z73) of “Problems Related to Life-Management Difficulty”. Some other diagnoses in this section include “lack of relaxation and leisure” (Z73.2) and “Inadequate social skills, not elsewhere classified” (Z73.4). The code for burn-out is Z73.0

To demonstrate one way in which burnout may present itself, the following example of “Margaret,” although fictional, presents a scenario that many who have been in a similar field may relate to:

Examples

After working for almost a year in a government health agency, Margaret started to notice that she was getting increasingly annoyed by the bureaucracy and the multiple layers of approval required before changes could be made. She experienced frustration as she was able to see first-hand how some policies were negatively impacting her clients, but little was being done by those in management to address these concerns. Colleagues started to notice that Margaret became angry even walking into staff meetings, just anticipating what “garbage” was going to be thrown at the staff “this time.” It even started to affect her attitude towards the job. If Margaret was given a new referral, she immediately became defensive, sharing questions such as “why do I get all the difficult cases?” and even “why doesn’t this person just help themselves?”

Questions for reflection:

- Would you say that Margaret is suffering from burnout, and if so, what symptoms or organizational demands lead to your decision? What other information would you want to have before you “diagnose” Margaret with burnout?
- Do you think Margaret could be experiencing depression? What symptoms lead to your decision?
- Looking at your responses to both questions 1 and 2, would you say that burnout is a type of depression, or do you view them as different?

Social workers in any facet of the profession have the potential to become impacted by organizational stress or through the experiences of their clients. Some research has been done into individual factors that may exacerbate some individuals’ risk over others. Simionato and Simpson (2018) completed a literature review looking into the demographics of burnout. Overall, it seems that although some demographic factors could contribute to burnout, it is more likely a combination of personal and occupational factors. There are some issues that impact the research on demographic aspects which makes it difficult to validate, including the possibility that people who experience burnout earlier in their career may leave the profession, thereby pointing to work experience being a factor where in reality, the people more prone to burnout may have left the profession earlier. The research has also suggested the possibility that some personality characteristics may make a person more prone to burnout, including neuroticism, rigid thinking styles, over-involvement with client problems, perfectionism, and being introverted. Lloyd et al. (2002) identify that people who are vulnerable and/or idealistic are drawn to the profession of social work, which could make them more prone to work-related stress based on these inherent factors. Apart from that, they found that “all the other stressors are contextual and relate to organisational and role deployment issues” (Lloyd et al., 2002, p. 262).

Compassion Fatigue

Whereas burnout is about the impact of organizational factors, compassion fatigue and vicarious trauma are about the impact on the professional when working with traumatized individuals. Compassion fatigue is how much care we give to others at the expense of ourselves and involves the professional themselves experiencing symptoms of trauma. Symptoms of trauma may include emotions of fear or anger, physical reactions of having a strong startle response (“jumpy”) and muscle tension, sleep disturbances, flashbacks, nightmares, and cognitive distortions also can be part of the experience. According to Figley (2002):

> Compassion fatigue is defined as a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g., anxiety) associated with the patient. It is a function of bearing witness to the suffering of others. (p. 1435)

Figley initially developed the Compassion Fatigue Resilience Model in 1995, to demonstrate the risk and protective factors that either increase or decrease a person’s risk of developing compassion fatigue. This model acknowledges that empathy and

compassion are cornerstone to a helping professional being able to be present and of benefit to their clients, but that with this comes risk to the helper themselves. It has evolved over time, and now includes thirteen variables:

1. Exposure: it is necessary for the professional to have exposure to the client who is experiencing suffering.
2. Empathic ability: The helper needs to also have the capacity to notice the pain of others.
3. Empathic concern: The professional should have the interest and willingness to respond to the pain of others.
4. Empathic response: The above three variables lead to the empathic response, or how much the professional engages and tries to help ease the suffering. The empathic response can be present in varying degrees depending to what extent the three contributing variables are present. If low, this can be a risk factor to developing compassion fatigue, along with the following four variables.
5. Traumatic memories: of the therapist related either to their personal trauma or to trauma of other clients.
6. Prolonged exposure to suffering: continued engagement with suffering individuals, with limited breaks.
7. Other life demands: other events happening in the professional's life outside of work.
8. Compassionate stress: one experiences, which is the pressure to be compassionate, that the professional feels.

If certain protective variables are not in place, the factors listed above can lead to compassion fatigue, or if they are in place, can promote compassion fatigue resilience. The protective variables, which help to offset the risks, include:

1. Sense of professional satisfaction: sense of accomplishment from the work
2. Social support
3. Detachment: taking a mental and physical break from the work; providing some distance between self and the client's problems between sessions
4. Self-care: defined by Figley and Figley (2017) as "the successful thoughts and actions that result in improving or maintaining one's good physical and mental health, and a general sense of personal comfort" (p. 10).
5. Compassion Fatigue Resilience: on a subjective scale from low to high, how resilient the care provider is to developing the symptoms of compassion fatigue. The lower the risk factors and higher the protective factors, the more resilient the provider will be.

Consider this hypothetical case scenario in the context of compassion fatigue:

Examples

Mark is a social worker in a hospice setting where he provides support to the dying and their families. After being in this position for a few years, where he was able to disconnect from his work at the end of the day, he lost his own mother to cancer. After that he started identifying much more with what his patients' families were going through and found he had a more challenging time disconnecting. He was spending longer hours at work because "these families need me." When he went home at the end of a shift, he was not able to engage with his family as much as before, "zoning out" when his children talked about their school day. He started numbing with alcohol and spent his "free time" reading about death and bereavement in an attempt to further understand what both he and his work-families were dealing with, taking away from time he could be spending with his wife and children.

Questions for reflection:

- What do you identify as being the risk factors to Mark experiencing compassion fatigue?
- What are his protective factors?
- If you were one of Mark's support people, what suggestions would you make to him that could improve his compassion fatigue resilience?

A similar concept to compassion fatigue is empathy fatigue, which was coined by Mark Stebnicki in 1998. This condition refers to a professional who has an empathic relationship with another individual, and experiences symptoms similar to those of compassion fatigue or vicarious trauma. It is more a response of the professional's own trauma history or stressors to the client's stories, not a direct result of client traumas. It presents as exhaustion on all levels: mental, emotional, social, physical, spiritual, and occupational (Stebnicki, 2008). According to Stebnicki (2008), there are six main principles of empathy fatigue:

1. It can occur at any stage of a person's career, even early on, and may be dependent on the person's age, personality, coping abilities, and personal and professional supports.
2. The professional themselves do not always notice the onset or warning signs.

3. If a professional is affected by empathy fatigue, they are not practicing ethically or competently, similarly to other forms of impairment.
4. The effects are on a spectrum and do not follow the same path for every professional.
5. The effects are often noticed by others, even if not noticed by the individual themselves, and therefore adequate clinical supervision and other professional support is necessary.
6. It is the professional's perception, not the client's traumas or stressors, that contribute to empathy fatigue. This is to say that as individuals, we all have our own histories, and it is how our clients' stories combine with our own responses that contribute to the amount of empathy fatigue we will experience.

Compassion fatigue and empathy fatigue share some commonalities, but there are also distinctions. One of the differences is based on the different definitions of "empathy" and "compassion." Compassion is having a desire to help, while empathy is relating to the experiences of another. The more empathetic a professional is and the more empathy they experience and convey, the higher risk they are for developing empathy fatigue. Take, for example, the following difference: the social worker who uses a trauma therapy approach to assist a client with significant past trauma versus the social worker who empathically relates to a client who is going through a divorce and is struggling financially now as a single parent on a limited income. Stebnicki (2008) would suggest that the latter is at higher risk for empathy fatigue because of the extent to which their own personal emotional energy goes into relating to that client. Empathy fatigue is seen as more of a cumulative effect where compassion fatigue can have a more rapid onset.

Vicarious Trauma

Vicarious trauma is similar to compassion fatigue in that it evolves from secondary exposure to trauma through our clients' experiences; however, unlike compassion fatigue it involves a change in the helper's worldview and may or may not include trauma symptomology. This is a cumulative effect, building up over time (O'Neill, 2010a). Beyond the experience of compassion fatigue, vicarious trauma changes how an affected person views the world. This is, for example, when the social worker hears client stories of domestic violence and now believes that all relationships are unhealthy, or one who works with female survivors of sexual violence and now believes that men, in general, cannot be trusted. In the words of McCann and Pearlman (1990), "it is our belief that all therapists working with trauma survivors will experience lasting alterations in their cognitive schemas, having a significant impact on the therapist's feelings, relationships, and life" (p. 136). This points to the intensity of the work we do as professionals in the business of working with society's most vulnerable.

Vicarious trauma is not a new concept. The negative impact on helping professionals has been noted for a long time. A few decades ago, McCann and Pearlman (1990) developed constructivist self-development theory to explain the effect other peoples' trauma can have on another person experiencing it vicariously. This theoretical model essentially says that we all have our own ways of viewing the world, and when these views are challenged by having conflicting information provided to us through experiences, directly or indirectly, our worldview changes. If we believe the world to be a generally safe place but then hear someone's experience of being a victim of violence, this can affect how we perceive the world as well. This is also why vicarious trauma tends to be a gradual effect. Hearing one traumatic story might not make a person believe in the general lack of compassion in humans but hearing story after story with a similar theme can.

The following fictional scenario of "Sheryl," demonstrates how vicarious trauma can develop and affect the individual:

Examples

Sheryl is a social worker in a sexual violence program at a community-based agency. After working with several women who had been abused and hearing intimate details of the assaults and the ongoing impacts on them, Sheryl began to lose her trust in men. Where previously she had been social, going out with friends and on the occasional date, she now began to isolate and removed her online dating profile. She no longer trusted men and did her best to not encounter them alone. Even if she were on an elevator and a man got on, she would often get off, even if it was not her floor.

Questions for reflection:

- How does this presentation differ from the examples of burnout and compassion fatigue?
- One marker for the development of vicarious trauma is the change in the individual's worldview. How do you think the mental health consequences of Sheryl's job would have been similar or different if Sheryl had previously been the victim of intimate-partner violence herself?

Impacts on Mental Health in a Rural/Remote Context

With the research showing that burnout and other work-related stress is more related to organizational factors than individual ones, let us now turn our attention to some of the impacts of mental health strain specifically through a rural/remote lens, as the working conditions in this context are often different than in urban settings. Consider the following scenario:

Examples

You are a social worker who has been hired by a non-profit agency to provide support to families who have been exposed to domestic violence. Your primary role is to provide counselling to women who have been victims of abuse. In this office it is just you and one other social worker who is also in the role of supervisor. You begin offering counselling support to a woman after receiving a referral from the local child protection agency, who had become involved because the couples' three children, ranging in age from four to eight, have witnessed some of the violence, which always reportedly occurs when one or both parents is using substances. Although your role is to work with the woman, the child protection agency has set a requirement for the husband to get counselling for his anger and for both parents to address their substance use issues. As well, the two eldest children are demonstrating some acting-out behaviours at school. As this particular community has no programs for men, nor for addictions, and the school does not have a counsellor on-site, you are asked to take on all these roles: domestic violence counsellor, anger management counsellor, couples' counsellor, children-who-witness abuse counsellor.

This is not necessarily unrealistic in rural social work. One person may wear many hats when it comes to service provision. As you think about this scenario, imagine this is you and consider the following:

- How might you feel about being asked to take on more than you had agreed to when you took the job?
- Think about the ethical implications and consider how you might respond: maintain your boundary of remaining within your job description even if it means the family does not receive all the support they need to stay together, while limiting your stress level, or offering all the various supports while potentially placing increased pressure on you.
- Now think about this scenario from the perspective of the child protection social worker who is also doing their best to protect the family and keep them safe and together, having limited resources to refer out to. How might it affect your practice if there is no one available to offer the various supports? How might you help the family to be safe if you are limited in the services you can access?

This is often the reality of working in a small or remote community where the resources are limited. That might be okay if you are a seasoned social worker who has experience or at least feels comfortable and competent working in all these areas, or if this is the only family you have on your caseload and you have access to training to support you, but these conditions are rare.

Rural agencies often hire new social workers who are seeking experience at the beginning of their careers. That experience can be overwhelming given that there is also likely little support offered. Refer to the beginning of this chapter and the contributors to burnout. What do you notice? Which of the six factors do you identify when you look at the above scenario? Quite possibly a high workload demand given that you are one of only two social workers and the other has other responsibilities to attend to. You also have limited control over your role since you are being called upon to do more than you were hired to do. Depending on your relationship with your supervisor and how over-worked they are, you may or may not receive much positive feedback, and support you receive from colleagues is limited by the small workplace community. What you are being asked to do may also not be consistent with your personal values. If you accepted this role to support victims of domestic violence, it may be outside of your comfort-zone to be asked to work with the perpetrator as well. In their review of the literature around social work and burnout, Lloyd et al. (2002) identify that the general population sometimes does not understand the role and work of social workers, resulting in lack of support for their expertise and experience, which may be a cause of burnout. This review refers to several authors in saying that people often think social work is just being nice or doing the things "that anyone can do" (Lloyd et al., 2002, p. 257). The issue of role ambiguity is prevalent in the literature as a contributing factor to burnout. In rural or remote locations, where resources are limited, there is the issue of roles not being understood but also, due to the lack of other referral sources, social workers may be asked to take on duties outside the scope of what they have been hired to do, forcing them to become a generalist practitioner. Riebschleger et al. (2015) look at the matter of child protection social work in rural communities and identify many of the same issues: lack of resources and minimal funding, all in the context of higher rates of poverty and substance abuse as is common in rural and remote areas.

There are several factors that social workers in rural/remote workplaces need to contend with that are not necessarily present to the same extent in urban locations. O'Neill (2010a) identifies some of these factors as "increased need for flexibility, personal independence and creativity, risk of professional and personal isolation, and limited community resources and lack of referral sources" (p. 3). Much as our hypothetical social worker experienced, they needed to become generalists because other services were absent. The circumstances in which burnout can occur include workload demands and lack of control or autonomy, so being expected to do more than you initially agreed to, and sometimes in situations of not feeling competent in some areas, will have a negative impact. It could be argued that this is an even higher risk for social workers in remote settings where there are fewer people doing the work. Riebschleger et al. (2015) refer to research, although based in the United States, that talk about the strongest predictors of child welfare workers leaving rural work, which include low levels of work-life balance and not feeling effective or satisfied in their jobs.

These differences between working in rural and remote locations versus urban ones also contribute to social workers experiencing burnout or secondary trauma differently. As Linda O'Neill (2010a) identifies, "informal reports suggest that northern practice may be detrimental to longevity in the field for mental health practitioners, especially those who come from outside northern communities" (p. 2). Part of the reason for this may be found in some of the issues already identified, in terms of lack of anonymity and isolation both personally and professionally. However, the nature of the work is often different in these locations based on the clientele and presenting issues. When you look at the make-up of Canada and which communities tend to be considered rural or remote, much of the population in these areas is Indigenous. We know the long-standing history of the trauma that Indigenous people have experienced in Canada and the inter-generational effects today. According to Canadian Census data collected between 2011 and 2016, suicide rates among Indigenous people in Canada are three times higher than non-Indigenous people, and nine times higher among the Inuit (Kumar & Tjepkema, 2019). High levels of primary trauma inevitably lead to high levels of secondary trauma for those trying to help.

Social factors can also contribute to some of the negative impacts on a social worker's mental health, whether that be cultural norms or socio-economic influences such as high rates of poverty or homelessness. These cause the potential for value conflicts between worker and location. Consider this example of "Penelope," which demonstrates value conflicts along with the experience of perceived inability to help, or to effect change, in a setting in which it is difficult to separate from this reality even during non-working hours. Although fictional, Penelope's experience is not uncommon, particularly for social workers working in communities quite different from their own:

Examples

Penelope is a social worker in a remote northern community working in a mental health setting. She has had several female clients who are experiencing domestic violence. Not only does she experience hopelessness and frustration at the lack of supports available for these women in the community, but she also sees how few options there are for women living with abusive partners. Homelessness rates are high, so it is not an option for many of these women to leave their partners and move out on their own. Unemployment rates are also high, so financially it is not very feasible for women to branch out on their own. Often when she goes out in the community, Penelope notices women with black eyes and bruises on their arms, and she is disturbed by how domestic violence seems to be normalized to the extent that women often do not even try to hide what is happening behind closed doors.

Question for reflection:

- When you read the above scenario, did you assume Penelope was from this community, or from elsewhere? Why? How do you think her response would be different if she were from this community or from away?

There are two types of social workers working in rural or remote communities: those who are from the community, and those who are not. Both come with their own sets of challenges. Moving away from what one is used to and into a completely new setting without the predictability that comes with it can be an adjustment for anyone. Moving to a community with perhaps a different culture, customs, and lifestyle than they are used to brings a new set of challenges. Many of Canada's remote communities have high Indigenous populations. Although this cross-cultural exchange can be exciting and provide new opportunities to both the professional and the community, there are also potential challenges in being viewed as an outsider. For instance, the professional may not understand the culture and idiosyncrasies of the community dynamics, channels to achieve change, politics, customs, and history. Sometimes professionals moving into a community are afforded opportunities not provided to the locals; for example, housing provided to professionals can be a barrier when many members of the community struggle with housing instability, or

access to better-paying jobs because of the opportunity to have gained an education. This contributes to the "outsider" effect and assumptions based on ethnic stereotypes. Navigating these systems and differences can cause a lot of stress. Take the example of "Steve," who portrays the experience of guilt over the allocation of resources and how this is viewed differently by the different populations involved:

Examples

Steve decided to move out of the rat-race of city-living and give living and working in a northern community a chance. This community was desperate for qualified social workers, so housing was provided, albeit at a cost. Once Steve got settled in his home, at his job, and started making some social connections, he started to notice comments being put on local social media platforms about the housing crisis in the community and the perceived unfairness of outsiders getting housing when so many of the local residents struggle with homelessness. This led to Steve feeling like even more of an outsider and contributed to feelings of guilt over his comparative resources.

Questions for reflection:

- Even though his living situation is not directly work-related, can this still potentially have a negative impact on Steve's ability to do his job effectively?
- What ways can you think of that Steve's mental health might be negatively impacted?
- What are the ethical implications, and how might Steve address the situation if called out on this privilege by a client?

Being a member of the community and transitioning to a different role is also a challenge in rural settings in that the social worker may be related to or know the community members, who may become their clients, on a more intimate basis, causing changes in their relationships and pose issues of confidentiality. This brings up some ethical dilemmas, particularly with respect to confidentiality and dual relationships, which can exacerbate work stress, particularly if combined with a lack of supervision opportunities. There is also the added component of a shared trauma history between professional and client (O'Neill, 2010b) which the worker may need to do some personal work on to promote healing in themselves so as not to be further triggered in their work setting. Consider the following fictional scenario of "Susie":

Examples

Susie, an Indigenous woman, was the first member of her family to go to university. She graduated with her social work degree and was excited to return to her community after 4 years away to work and to make a difference in the social circumstances there. She started working at an organization whose focus was keeping families together, through providing counselling services, advocacy, and supervised visitation upon the referral of the child protection agency. Shortly after she started there, her parents and brother organized a gathering to celebrate her graduation and invited members of the community. Susie was surprised to find that she received a cold reception from some people who believed that Susie was helping to reinforce systems of keeping families apart. This was particularly hurtful because, as having being part of the foster care system herself for a brief period as a child, Susie believed strongly in keeping families together wherever possible, while also recognizing that this is not always what is best for vulnerable children.

Questions for reflection:

- Why do you think the community is wary of Susie retuning to the community, even though they know her? What are they afraid of?
- How might Susie win over her community again?
- Considering the history of colonization in Canada among Indigenous populations and the impacts of intergenerational trauma, how might the community members have treated an "outsider" differently than they treated Susie?

Confidentiality and anonymity are factors that are more likely to come up in smaller communities where there is a higher likelihood of seeing clients in your personal time. Trying to navigate confidential situations can be challenging: do you acknowledge the client you see in public and risk "outing" them as a client? Or do you ignore them and risk their feeling rejected? And what about if you learn something about your client outside of the office space that may need to be addressed in it? For example, you are working with a client on their alcohol addiction and then see them drinking at the local pub. How does one navigate this? Addressing this potential in the professional setting, discussing this possible situation beforehand, can prevent awkwardness later on. Is keeping to yourself, then, the best option to prevent these possible circumstances? O'Neill (2010b), in her research among rural helping

professionals in northern BC and the Yukon territory, identifies the balance sometimes needed when working as an “outsider” in a rural/remote community in that staying an outsider will have you missing out on a lot, but being too involved in the community may lead to more dual relationships. Graham et al. (2008) bring to attention the issue that it is more challenging to prevent dual relationships in smaller settings but that there is a cost to not even trying: “If practitioners were to take seriously the view that all dual relationships must be avoided completely, they would most likely not be able to practice in such settings” (p. 400). It is about balance: communities need social workers (and all professionals), so if this means there will be some overlap in personal and professional relationships, the benefits likely outweigh the challenges.

A significant component of good mental health is placing energy in various areas of one’s life as opposed to just one or two, which includes work-life balance. In smaller communities, a social worker’s life can be impacted even on their personal time, which can affect how they choose to do their self-care, a protective factor against the negative impacts on their mental health. As mentioned, lack of anonymity, seeing clients in the community, even having people know where you live are often realities. Any hobbies the rural social worker enjoys participating in may pose challenges because of the small number of people to draw from who may share the same interests. Becoming involved in the local play production, joining the community band or choir, attending an arts or language class: these are all potentially-awkward situations for the social worker to navigate. It is difficult to fully relax and enjoy an activity if one believes they might be under scrutiny from others. Depending on the role we play when our social work hat is on, physical safety may be an issue; think of child protection social workers who may have had to intervene with a family who is very angry at such intervention, or a mental health social worker who phoned the police to check on a patient at home. The self-care practices, the things we do to reduce our stress and to off-set the negative impacts of stress, are therefore sometimes hindered.

Consider this example of a social worker whose personal time was affected by an ethical dilemma:

Examples

Melissa is a child protection social worker. She has been working with a family where domestic violence is the primary concern. As a result, there is an order in place stating that the father cannot have unsupervised access to the children and any contact must have the pre-approval of the social worker. One evening while Melissa is waiting in line at the local swimming pool, she notices the family in line ahead of her: both children and both parents. Although there on her own time to participate in a healthy activity for her own physical and mental wellness, Melissa considers her ethical and professional responsibilities. She ends up phoning the after-hours child protection line and being directed to intervene, spending the rest of her evening making alternative plans for the children after the breech of the order. After this experience, Melissa is hesitant to go public places for a long time.

Questions for reflection:

- Should Melissa have ignored this situation, or pretended she did not see the family? If you were her, how would you have felt if you ignored what you saw? Refer to the Canadian Association of Social Workers Code of Ethics to guide your decision. Which of the values are most relevant?
- Is this situation as likely to occur in a more urban setting?
- Think for a moment about how comfortable you would be in the above scenario and how you might handle it. Is this something you are prepared to face? Or is it more important to you to have your anonymity and a greater distinction between work and personal life.

Stress and burnout impact the individual social worker, but it also has impacts on the system at large. O’Neill (2010a) provides some context as to the vastness of the remote locations in Canada and brings to light the issue of limited resources, meaning more stress on the people doing the work. Preventing burnout and mitigating the effects of secondary trauma is essential in trying to retain the perhaps few professionals present, and to prevent the high turnover rates often seen in rural and remote environments. In their literature review on the impacts of burnout on mental health professionals, Morse et al. (2012) point to several negative outcomes including neck and back pain, sleep problems, depression, anxiety, substance use, and other problems related to the circulatory, respiratory, and digestive systems. From an organizational perspective, these authors found that employee burnout has a range of negative impacts. Not surprisingly, employees who are burned out will be away from work more often (absenteeism), are more likely to leave their jobs; the resulting employee turnover/retention problems can be costly to the organization. These problems also affect the quality of services clients receive as the burned-out employee may not put as much effort into their work and may not adhere to best-practice standards.

We see that the job impacts on the social worker can differ for multiple reasons, including individual factors, the organization and organizational culture, and location (rural vs urban). Whether or not we are from the community in which we are working will make a difference, as is how involved or distant we are from the community members and activities. Because no two social workers are the same, nor every community or organization, there is no "right way" to mitigate the negative mental health effects, so finding what works for the individual is essential.

Promoting Mental Wellness

We have seen how working in relative isolation can negatively impact our mental health, but what can be done about it? The motivation should be high for us as helping professionals to maintain our mental well-being not only for ourselves but also so that we can show up for the people we serve. In their book on trauma stewardship, Laura van Dernoot Lipsky and Connie Burk (2009) acknowledge that "people who are working to help those who suffer, or who are working to repair the world to prevent suffering, must somehow reconcile their own joy- the authentic wonder and delight in life- with the irrefutable fact of suffering in the world" (p. 16). In other words, be cautious not to feel guilty for enjoying your own life while others are experiencing distress. Everyone has their challenges. Just because one person seems to be struggling more than you does not diminish the depth of your own challenges or successes. You need to avoid comparing yourself to others as you move forward through your career in social work.

As we have seen, mental health is an issue that has consequences for the organization as well as the individual, so exploring changes that can be implemented at both levels is crucial. Organizations can be agents of change, but change can be slow to implement if it is even recognized in the first place. Depending on the size of the organization and the distance between decision-makers and workers on the front-line, change may be easier or more challenging. A problem cannot be solved if no one knows about it, so speaking up about our areas of struggle can be a great place to start. For example, having conversations about workload or opportunities for training to feel more competent, as well as advocating for adequate orientation on the job and addressing role ambiguity.

Some research suggests that higher levels of social support (personal and professional) increase compassion satisfaction and decrease burnout among helping professionals (Killian, 2008). In fact, this researcher discovered that helping professionals working in a team environment had higher job satisfaction and less psychological stress, and that the more contact the helper has with traumatized individuals in a week, the lower their compassion satisfaction. If support and a team-based working environment are mediating factors in causing burnout from workload demands, then those working in remote locations with few co-workers are missing out on this benefit. Developing a system of support for social workers in such settings can reduce the potential negative impacts of workload demands. Manning-Jones et al. (2016) identify three primary factors to promoting mental wellness among helping professionals, social support being one of them. All types of support—peer, family/friends, and professional—were shown to be of benefit. The other two processes noted by these authors are self-care and humour. The emphasis in the research on the importance of support, both personal and professional, in maintaining mental wellness stresses the need for adequate supervision. Unfortunately, in rural settings where agencies tend to have fewer staff, the level of supervision a social worker gets is not always adequate. Morse et al. (2012) identify some leadership strategies that can support social workers' mental wellness. This includes helping to reduce employee feelings of inequity by offering opportunities to meet the needs of the individual as well as the organization. As burnout is highly related to organizational factors, these authors also identify literature that addresses organizational strategies to reduce burnout, including increasing social support as well as regular supervision, both formal and peer; allowing employees to be a part of decision-making about their roles; reducing job ambiguity; decreasing workloads; and training supervisors about communication and the importance of all these factors.

Training is another issue that arises, as competence in the field contributes to better mental health and a belief in one's power to affect change. Adams and Riggs (2008) explore some of the factors that lead to higher risk of vicarious trauma among therapists, and one of their findings is that therapists with less experience tend to have higher rates of symptoms of trauma in themselves. They argue for better training of individuals who will be doing the work, and not just a one-day workshop. Because in a rural or remote setting social workers cannot always control the type of work they end up doing or the clientele they see, accessing supervision right from the start is imperative to maintaining their wellness and their perseverance in the profession.

We cannot rely solely on organizations to change or just hope that we have a supervisor who has the time, energy, and experience to provide what we need. From an individual perspective, there are some actions we can take to put our mental wellness in our own hands. Before even moving to the community, it helps to do some research to familiarize yourself with it, including the culture (which includes challenging your own cultural biases), what resources are available, how decision-making occurs, historical and

intergenerational trauma, and socio-economic concerns. Van Dernoot Lipsky and Burk (2009) note that our own personal history can impact our response to the work we do. If we have our own trauma history, we may be more, or differently, impacted working with a particular traumatized population than someone without that lived experience. Therefore, considering why you are choosing the work you do and taking regular stock of whether this continues to be a positive choice for you, may assist in either continuing in accessing supports of your own, or even making the decision to transition to another stream of work.

In their literature review on burnout, Morse et al. (2012) look at studies focused on the reduction or prevention of burnout among mental health professionals. Some of the interventions they identify are recognizing training needs and then accessing such training, both strategies to help their mental health clients/patients, and cognitive behavioral strategies for managing their own symptoms, improving coping skills, mindfulness, meditation, and gratitude. Other authors have noted the same. Cohen and Collens (2013) completed a metasynthesis of the research on post-traumatic growth, looking at the themes that arise for trauma therapists. One of the themes identified was ways of coping with the traumatic information professionals hear from their clients. In addition to some organizational factors, many of which have already been identified in this chapter, they found some individual coping skills including exercise, healthy eating, rest/meditation, taking holidays, socializing, watching movies, political activism, keeping a sense of humour, and psychotherapy. They also highlight the strategy of finding ways of detaching from work during personal time. Similarly, Manning-Jones et al. (2016) have found that social support, self-care, and humour are three coping strategies to offset the effects of secondary stress.

Professional identity, especially seeing oneself as helper, is also noted in the literature as promoting self-care and longevity in the field. Van Dernoot Lipsky and Burk (2009) talk about trauma stewardship and use a model of five directions to encourage us to do a daily reflection on a few areas, including asking yourself what is your “why” for doing the work you do, focusing on what is within your control, developing and maintaining social connections, having balance, and practicing mindfulness. In doing this, we can be assured that where we are choosing to put our professional efforts continues to be in line with our values and capabilities and puts the onus and control on ourselves to either maintain or to change tack if we recognize the need. As humans, we all have limitations. Ignoring these and trying to push forward at the expense of our own mental and physical health will do nothing to help neither us nor those we are trying to serve. This connects to having belief in the work we do (O’Neill, 2010b). What keeps us going even on the most challenging of days and with the most challenging of clients is the belief and hope that change is possible. Consider this example of Mary, who has put a lot of effort toward ensuring she becomes a community member, not just a professional outsider:

Examples

Mary started working in a predominantly Indigenous community directly out of finishing her Bachelor of Social Work degree. She was eager to get into the workforce and begin what she was sure would be a long career as a helper. Although faced with some initial challenges with being accepted into the community, and some embarrassing experiences in which her ignorance of the local culture showed, she persevered. She was active in the community and never passed up an opportunity to attend a cultural event. She continued to have her struggles as the nature of her job was not always conducive to having people like her, but her connection to the community re-enforced why her work was so important.

Questions for reflection:

- What do you think contributed to Mary’s success in integrating into the community?
- What do you think contributed to some of the challenges Mary experienced at first?
- From the perspective of community members, how might they have thought about Mary immersing herself into their community and culture?
- How might Mary’s experience have been different if she was trying to immerse herself in an urban community?

Valent (2007) identifies eight possible survival strategies in response to trauma: “fight, flight, rescue/caretaking, attachment, goal achievement/assertiveness, goal surrender/adaptation, competition/struggle, and cooperation/love” (p. 4). O’Neill (2010a) points to four of them (flight, cooperation, attachment, and acceptance) as being most utilized by mental health practitioners living in the north. Flight– from the commonly-acknowledged “fight/flight/freeze” response to perceived danger–is escaping from a potential threat. In the context of coping with rural social work, this response manifests in several ways: isolation from society, not participating in the community other than going to work; leaving the community on weekends or taking vacations away; or leaving the community entirely. Cooperation is just as it sounds, meaning working together without competition, or pooling resources.

Along with support, cooperation is vital to working in isolation, especially when there are limited resources. Valent (2007) argues that "loving relationships and social networks may protect not only against cardiovascular disorders but also against a variety of traumatic stress and other disorders" (p. 11.) Attachment, as we have already explored, is an important part of being a human. We do not live or thrive in absence of human connection. Living in isolation often necessitates an even greater need for attachment to our support system. Acceptance is what Valent (2007) refers to as goal surrender or adaptation: "it demands delaying or surrendering goals, grieving losses, and adaptation to new circumstances" (p. 9.) From everything we know about working in isolation, this makes sense. If we try to hold on to the way things were when we were in an urban setting with more resources and supports, we will quickly get dragged down. Valent (2007) talks about the grieving process that sometimes comes when we recognize the need to adapt to a new way of being and working.

There are some challenges to working in rural or remote locations that urban centres do not necessarily have to contend with, but the news is not all bad. There are many benefits to working in rural communities. Riebschleger et al. (2015) point out that rural practice may involve more independence and collaboration with other agencies, including multidisciplinary teamwork, and engaging with community members on a formal and informal basis leading to developing good working relationships. Focusing on the positives that can arise from working in smaller and remote communities can provide an attitude that will be beneficial in maintaining mental wellness.

There is also some good that can come out of exposure to the types of trauma social workers experience. Some research indicates that people who have experienced trauma, including those who experience it vicariously, can be positively impacted by it. The term posttraumatic growth has developed from this, which is "the process of developing new strengths, stronger relationships, expanded coping mechanisms, and psychological understandings that incorporate trauma experiences" (Regehr, 2018, pp. 7-8). Some benefits can be seen such as increased sensitivity, compassion, and insight; an increased appreciation for the resilience of the human spirit; and an increased sense of the precious nature of life (Arnold et al., 2005 as cited in Regehr, 2018, p. 8).

Professional and vicarious resilience occur when those who work with vulnerable populations thrive in this high-stress environment (Newell, 2018). According to Hernandez et al. (2007), who developed the concept of vicarious resilience, the resilience of people who have experienced trauma is felt by the helper. Those whose work does not expose them to people in their most vulnerable state may never feel the joy of seeing a person finally overcome an obstacle they have been struggling with for a long time or feel the satisfaction of helping someone see themselves or someone else in a new light, as in the case of "Philip" below:

Examples

Philip is a child protection social worker. He has been working with a family over the past couple of years. Through that time there have been some successes but also some challenges. Twice he had to remove the children and place them in temporary foster care arrangements. After the last removal, the single mother went away to a residential addiction treatment program and successfully completed it. She has been sober now for 4 months and has found employment and stable housing. The children are back living with her, and Philip is preparing to close the file after one final home visit. Philip reflects on the last couple of years and feels a sense of happiness and hopefulness for this family.

A question for reflection:

- One possible concern for professional helpers is putting our professional self-worth in the successes of our clients. That is, believing that if our clients are not progressing, this is an indication that we are not doing a good enough job. What are the risks in this for both the social worker and the client? As you prepare to move forward into a career in social work, what ideas do you have to prevent this from happening to you?

Conclusion

Take a moment to make a list of all your hobbies and interests outside of work or school. Include the places you like to go in your community, the people you socialize with, the events you like to go to, the sports or other organized activities you enjoy. Now imagine yourself working in a community with a small population, perhaps one that is also isolated with no big cities nearby. Knowing what you do now about maintaining your own mental wellness as a social worker in such a setting, how do you see these activities possibly being impacted? Would you feel comfortable going to all the places you identified? How might your choice of social contacts change in this context?

As a social worker in a small community, you do not have the luxury of anonymity. You are likely to face issues of dual relationships in that your activities may overlap with those of some of your clients. The more prepared you are for this happening, the more you can plan. Balance is essential. Finding an equilibrium between being overly visible in the community, attending every social event, joining every organized sport or activity versus staying in your home and only reading books and watching television when you are not at work will help you. Develop and strengthen your personal support system; arrange regular phone calls or Zoom dates with friends and family. Build supervision opportunities into your practice. All of these are factors within your control, and the more open you are to recognizing and accepting these factors as well as your limitations, the more prepared you will be to survive professionally in a place where you do not necessarily have all the resources available to others.

Finally, as a reminder to your "why," to help keep in mind why you continue to stick with it (whatever "it" may be):

The Boy and the Starfish (Loren Eisley[1])

One day a man was walking along the beach when he noticed a boy picking something up and gently throwing it into the ocean.

Approaching the boy, he asked "What are you doing?"

The youth replied, "Throwing starfish back into the ocean. The surf is up and the tide is going out. If I don't throw them back, they'll die."

"Son," the man said, "don't you realize there are miles and miles of beach and hundreds of starfish? You can't make a difference!"

After listening politely, the boy bent down, picked up another starfish, and threw it back into the surf. Then, smiling at the man, he said "I made a difference for that one."

Melanie Abbott: I am a 43-year-old Caucasian woman, pronouns she/her, born and raised in Canada. I hold a Bachelor of Social Work degree from the University of Calgary (2002) and a Master of Social Worker degree from the University of British Columbia Okanagan (2014). I have had the privilege of living and working in various communities around British Columbia, working primarily in Northern communities, and in the Nunavut territory for the past 4 years. I currently live in the Yukon territory while still working virtually in Nunavut and in other provinces across Canada. I recognize my privilege in working in largely Indigenous communities, having access to resources that others may not have, for example, housing and food security. I am always cognizant of this in my interactions.

Activities and Assignments

1. Create your own self-care/wellness plan. Prevention is better than intervention, so developing some self-care strategies now, at the beginning of your career, can go a long way in the mitigating of further problems. Keep in mind the wellness wheel format: how can you maintain or improve wellness in all facets. Refer to this at the end of your practicum and again a few months into your first job as a social worker and see how well you are maintaining it; make any changes as needed.
2. Search and complete the Professional Quality of Life Scale – The ProQOL 5 Self-Score (English) – on the ProQOL: Professional Quality of Life website in the ProQol Measure & Tools section to see how you rate on levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. If you are currently in a work or practicum setting, this exercise could provide insight into how your work is currently affecting you. Keep your scores and return to this later, once you have been working in the field of social work for a while, in order to note any shifts.

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1Adapted from "The Boy and Starfish," by L. Eiseley, 1969, The Unexpected Universe.

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Thriving in Rural and Northern Practice: A Place-Based Approach

1

Joanna Pierce and Tavia McKinnon

Social work education in Canada focuses largely on theories, skills, and ethical frameworks that are congruent with urban settings. As a result, social work in rural, remote, and northern regions is often defined in relation to urban (and southern) expectations of practice. This approach tends to emphasize the deficits of rural, remote, and northern practice, while paying less attention to the reasons why social workers choose to live and work in northern remote places over the long term. The first section of this chapter centres on a discussion about the characteristics of rural, remote, northern, and urban places. The second section provides a brief overview of the literature on rural, remote, and northern social work, and unpacks deficit-based narratives about practicing in these contexts. Finally, building on Zapf's (2009) proposal of "people as place" and drawing on the authors' extensive experiences in northern and remote places, the third section presents a place-based approach to practice that encourages social workers to ground themselves in the local community and reflect upon their own connections to place.

Learning Objectives

By the end of this chapter you will have had the opportunity to:

- Understand the terms rural, remote, urban, northern social work
- Understand/identify differences between urban, rural, remote, and northern social work practice
- Develop awareness of personal connections to place
- Consider place-based implications for practice

Defining Rural, Remote, and Northern Places

Just as "social work" is used to refer to a broad spectrum of roles and responsibilities, the terms "rural," "remote," and "northern" encompass significant diversity, both in terms of geographic location and in the cultures, values, and livelihoods of the people who call these places home. Awareness of this diversity is an important first step to place-based practice. For now, it may be helpful to look more closely at what is meant by rural, remote, and northern in the context of social work in Canada.

Urban, rural, remote, and northern hold multiple meanings that vary widely internationally, based on geography, climate, and population size and distribution. For example, while "north" in the Canadian context often carries a connotation of freezing temperatures and a harsh climate, the same does not hold true for Australia, where harsh climates are associated with extreme heat. Similarly, while in Canada many remote communities are located hundreds of kilometres from their closest neighbour, the meaning of "remote" may be understood differently in countries with a different population density and geographical size.

Even within Canada, classification of urban, rural, and remote remains an ongoing subject of debate (Subedi et al., 2020). Generally, urban places are defined by a combination of high population size, high population density, and/or proximity to major population centres, while rural places have comparatively low population size, low population density, and are located at a greater distance from urban centres (Statistics Canada, 2017a). Remote communities, in addition to having low population size and density, are characterized by their distance from other small communities and by more restricted access (Pierce, 2017). Air access, reliance on seasonal and weather-dependent travel routes–such as ice roads, gravel roads, and ferry crossings—or travel through isolated regions may be required to access the nearest major centre.

While the above delineations can be helpful in clarifying the use of the words "urban," "rural," and "remote" in this chapter, we also recognize that these terms represent living, dynamic communities made up of diverse people in unique contexts. In other words, no two communities are exactly alike, even if they share some characteristics such as a northerly location or a similar distance from the nearest city. Pugh and Cheers (2010) observe that while differences between urban and rural areas do exist, attempts to establish dichotomies between urban and non-urban areas often unhelpfully assume the presence of "some enduring essential or intrinsic feature of 'rurality' that can be found in all rural communities" (p. x). Like Pugh and Cheers, we choose to focus on the diversity of rural experiences, on grounding rural practice in its local context, and ultimately on the development of place-based solutions best suited to the needs and assets of local communities. Given the significant role of geography in shaping the experience of people in rural and remote places, it is also worth attending to the concept of "north," which has been the subject of considerable debate in Canadian literature on rural and remote social work.

How North is North?

In 2016, 66% of Canada's population lived within 100km of the country's southern border with the United States, an area that makes up just 4% of the country's land mass (Statistics Canada, 2017b). With the remaining third of our population spread out across a vastly larger geographical area, the terms "northern" and "remote" are sometimes – and understandably – conflated. However, one does not necessarily imply the other, in part because of Canada's geography and in part because "north" is a relative concept. For example, the city of Prince George, British Columbia, is located approximately 700km north of Vancouver and is the most northerly urban centre in all Canadian provinces; yet Prince George would almost certainly be considered "southern" by residents of more northerly communities in B.C. and the Yukon. Furthermore, despite Prince George's stated northerly location as compared to Vancouver, it is neither rural nor remote; rather, it is an urban centre that provides services to residents of many smaller communities throughout northern B.C.

Given the inherently subjective nature of "north" as a cardinal direction, another approach is to set geographical boundaries. One such approach is to consider anything north of the limit of isolated permafrost as "Canada's north"—an area which includes Nunavut, Yukon and Northwest Territories (sometimes called the "far north"), in addition to the northern regions of British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, and Newfoundland and Labrador (Government of Canada, n.d.).

Schmidt (2017), meanwhile, notes differences in the historical perceptions of north among Indigenous and Settler peoples, where "early European settlers (French and English) saw the north as something that was savage, hostile, and even fearful whereas the Indigenous people regarded the north as home and a place of safety" (p. 9). These differences hold important implications for the continued unfolding of north-south and Indigenous-Settler relations, particularly considering that urban and southern residents today often hold much of the power when it comes to defining and characterizing the "north" (Schmidt, 2009). Building on Kassam (2001), Schmidt also highlights the significance of the way we describe the north: if the north is seen as a place of belonging, or a homeland, then the sustainability of its people, communities, and resources are more likely to be upheld; however, if the north is "othered" and characterized as a frontier, it becomes easier to justify exploitative practices such as unsustainable resource extraction (Schmidt, 2009).

Despite geographical and political understandings of north, there are places where people identify as "northerners," and often this sense of identity is tied to specific local characteristics related to geography, climate, and culture. Pfeifer (2018), an Inuk scholar writing about Arctic research governance, states that "[w]e don't need Northerners to become better researchers, we need researchers to become better Northerners" (p. 34). If the same is true within social work, perhaps the first step is to learn from northerners what this means to them.

Examples

- You are about to start practicing social work in _____, a remote community only accessible by [state how it is accessed]. What might you need to take into consideration, both personally and professionally, in terms of travel?
- You are a social worker in the rural community of _____. The community is connected to the nearest city by an all-weather gravel road, and residents must go to the city for basic needs such as grocery shopping and medical appointments; however, many of your clients do not have access to a vehicle. How might this impact your practice?

Northern, Remote, and Rural Social Work in the Literature

The concept of rural social work practice dates back to the early 1900s. In the United States, social worker Josephine Brown was advocating for rural-specific practice as early as the 1920s and published a seminal book on rural social work in 1933 (Martinez-Brawley, 1987). Remarkably, many of Brown's observations and recommendations for rural practice are still relevant today. Her emphasis on a generalist approach to practice, developing strong relationships, making use of local resources, and developing awareness of local context have been echoed by contemporary rural social work scholars. However, Brown was criticized for much of her work at the time (Martinez-Brawley, 1987) and, despite her efforts, the notion of rural-specific social work in the United States was mostly superseded in the 1940s by urban priorities of social work specialization (Schmidt, 2009). Despite a resurgence of interest in rural social work in the United States in the 1970s, studies began emerging in the United States and Australia in the late 1980s and 1990s that questioned the existence of any empirical differences between social work practice in rural and urban areas (Pugh & Cheers, 2010; Schmidt, 2009). However, Pugh and Cheers (2010) contend that these studies focused on patterns and practices largely pre-determined by broader structures of social service provision, as well as on practitioner perspectives likely shaped by the common denominator of social work education in urban centres. As a result, the studies may have neglected to

consider factors relevant to small communities in rural areas, such as ethical considerations related to confidentiality, balancing work and personal relationships, and relationships with the larger community (Pugh & Cheers, 2010).

In the 1980s, while international scholarship focused on rural social work was unfolding, Canadian and international scholars began to explore the notion of remote and northern social work as separate areas of practice (Pierce, 2017). With growing interest around social work in northern and remote areas, researchers also began attending to historical relationships of colonization and exploitation between urban and remote places (Pierce, 2017).

With a focus on economy as a driving societal force, Collier (2006) describes the relationship between urban and non-urban places as a subjugation of rural and remote areas to fuel economic growth in urban centres. Rather than focusing on the geographic characteristics of communities, he outlines three phases of economic societies and focuses on the interactions between them as a context for rural and remote social work practice. Collier highlights the practice implications of differing worldviews, notes that an emphasis on economic "development" often serves to increase inequality between rural or remote regions and cities, and urges rural social workers to commit themselves to understanding the social structures of the communities in which they work. Amidst discussion of the social and economic characteristics of rural, remote, and urban societies, Collier's (2006) work largely fails to acknowledge the impact of local history, culture, and geography – all of which contribute to great diversity among communities that share similar economic roots – as well as the significant number of rural and remote social workers who work in or near their home communities.

Meanwhile, researchers at Canada's Lakehead University such as Delaney and Brownlee (1995) have historically taken a broader perspective (Schmidt, 2009). This perspective extends beyond Collier's political and economic take on rural and remote social work to consider elements of the northern environment and local communities – such as population size, relative isolation, and the presence of dual relationships – that influence the experience of living and practicing in northern and remote places (Schmidt, 2009).

Finally, scholars in Canada and internationally (Coates, 2003; Gray et al., 2013; Maidment & Bay, 2012; Zapf, 2009) have increasingly highlighted the need for social workers in rural and remote areas to develop awareness of the interactions between people, communities, and the natural and built environments in which we live. Fuelled by impacts upon marginalized communities, and recognizing the longstanding relationships of reciprocity between Indigenous peoples and their traditional territories, social work scholars have been exploring the myriad ways in which geography and place interact with human experiences and subsequently, with social work practice.

Unpacking Deficit-based Discourse

Literature on rural, remote, and northern social work focuses on themes such as culture shock for social workers newly arrived in remote places, staff burnout and retention challenges, lack of access to specialized services, experiences of isolation, and difficulty navigating dual relationships. As social workers with an ethical commitment to the pursuit of social justice and competence in professional practice (Canadian Association of Social Workers [CASW], 2005), we have a responsibility to attend to such concerns. However, we equally have a responsibility to attend to the diversity of the populations and communities with whom we work and to advocate for change when mainstream approaches are imposed in ways that hinder our capacity for competent, ethical, and contextually-responsive practice.

Pierce (2017) observes that there are social workers who thrive in rural, remote, and northern practice and whose experiences of living and working in small communities are not accurately portrayed by the predominantly deficit-based descriptions in the literature. This deficit-based focus is often problematic in several ways. First, painting all rural, remote, and northern places with a similar (and deficit-based) brush ignores the diversity of people and places and may lead to imposing decisions that worked well in one place upon other places, irrespective of local context. Second, focusing on what is not going well can result in missed opportunities to learn from successes and build on local strengths. For social workers raised and educated in urban centres, academic discourse may be a primary source of information on what it is like to live and work in non-urban areas. If the story told of rural, remote, and northern places is exclusively one of poverty, social isolation, and lack of access to city conveniences – a story of what is "missing" – this story not only discourages social workers from seeking work in these places but also suggests that this lifestyle is something merely to be endured, preferably over the short term. As a result, practice is often promoted through incentives such as remote pay allowances and accelerated career promotion upon return to an urban centre. This narrative subtly and invariably invites questions about why anyone might choose to live in rural, remote, and northern areas, which is hardly a

helpful mindset for social workers arriving in a community for the first time; it also may be particularly unwelcome for social workers (and other community members) who already call these places home.

Rather than continuing to look primarily at what is not working in rural, remote, and northern social work and what is considered lacking by urban standards, one alternative is to seek a more balanced view by exploring perspectives on what is working well and what social workers gain through experiences of living and working in smaller communities. Graham et al. (2008), for example, offer insight into both the successes and struggles experienced by social workers in remote northern contexts; the balanced view of their study may partly be attributable to the inclusion questions that specifically targeted negative and positive aspects of social workers' experiences. Similarly, Pierce (2017) intentionally explores the narratives of social workers in British Columbia who have chosen to live and work long-term in remote northern communities—narratives that may be useful in understanding how social workers come to thrive in place.

Another approach to avoiding urban-centred and deficit-based discourse is to move from comparisons of urban and non-urban social work towards a more place-centred approach. This notion, along with specific implications in rural, remote, and northern contexts, is the focus of the following section.

Examples

What are your own thoughts and opinions about northern places and people?

- How do you define north, and what do you consider a northern place?
- If you have experiences in northern places, how have these informed your beliefs about "the north" and what it means to be a "northerner"?
- If you have no (or few) experiences in northern places, where does your knowledge about these places come from? How do you know it to be true?

Place-Based Social Work

Within the considerable literature on rural, remote, and northern social work, many scholars have highlighted the central role of geography and place within social work practice (Maidment & Bay, 2012; Pierce, 2017; Pugh & Cheers, 2010; Schmidt, 2009; Zapf, 2009). More than simply an inanimate backdrop upon which human actions are carried out (Zapf, 2009), place has an active role and bearing upon human health, economy, politics, and social and cultural norms. People equally play a role in shaping place, through interactions with physical landscapes and by developing social meaning in spaces over time. Australian social work scholar Chenoweth (2012) describes the dynamic relationship between place and social meaning-making as follows:

> *Place is inextricably linked to the social, and is constantly being negotiated across social, cultural, historical and physical aspects of the environment. In rural areas, the history of and cultural meanings attached to landscape are influenced by the constant changing of place through natural events such as floods, droughts and different land uses. (p. 97)*

In agricultural communities, industry towns, and communities where hunting and trapping are important contributors to food security, people's health and livelihoods are often closely linked to the health and seasonal rhythms of their natural environment. For social workers new to rural or remote communities, developing an understanding of the relationships between people and place can provide a strong foundation for adapting and applying social work skills in a meaningful and relevant way.

People as Place

Zapf's (2009) proposal of "people as place" as a foundational metaphor for social work practice discusses the meanings of "place" and "space"; considers implications of place in rural, remote, and northern communities; and reflects upon Indigenous perspectives of land and place connection.

The "person-in-environment" model, which positions individuals in the context of their social environments, has been foundational to social work for several decades (Zapf, 2009). This approach to practice has encouraged social workers to look beyond individual factors, consider interactions within and between social systems, and integrate practice at micro, mezzo, and macro levels. The person-in-environment model has received criticism for not addressing the larger structural forces that create and reinforce social inequities (Zapf, 2009). Scholars writing about environmental and eco-social work have also critiqued the incongruency between

the language of “ecological” or “person-in-environment” approaches and the prevailing exclusion of natural ecosystems and built environments from social work discourse (Jones, 2010; Zapf, 2009). In a seminal contribution to the literature on social work and the environment, Zapf (2009) asserts that consideration of people’s natural and built surroundings – in addition to their social environments – offers a more holistic approach to practice. To aid social workers in accounting for the diverse environmental factors that influence, and are influenced by, individuals and communities, Zapf proposes a transition away from the traditional “person-in-environment” model towards a more integrative metaphor of “people as place.”

Drawing on Morito’s (2002) notion of ecological thinking, Zapf (2009) encourages social workers to go beyond simply “thinking about ecology” and instead cultivate the capacity to think more holistically about issues spanning social and environmental concerns (p. 24). In bringing together place-based thinking from multiple areas of social work, including rural and remote practice, spirituality and social work, Indigenous social work, and international social work, Zapf explores many existing entry points within social work that can contribute to discussions on the significance of place within practice.

Zapf also looks beyond social work to other disciplines, turning to the fields of geography, education, environmental design, sociology, and art (among others) to gain insight into the relationships between people and place. Together with social work and interdisciplinary knowledge, he advocates for a paradigm shift within social work that recognizes the connectedness of people and place. In response to Zapf’s call to action for social workers to find ways to integrate place into their work, we need to consider what is meant by “place” and how place intersects with social work practice.

Defining Place

As suggested by Chenoweth (2012) in her description of the reciprocal relationships between physical landscapes and social meaning-making, place is more than just a physical location. Looking to the field of human geography, “space” can be defined as a geographical area, while “place” exists within space and is defined by the meaning it holds for people who live there (Pierce, 2017). Put slightly differently, Zapf (2009) reasons that “place has something to do with location plus the meaning ascribed to the location” (p. 146).

Susan Kemp (2011) observes that place is both *dynamic* and *relational* and is subject to change over time and often evolves through interactions with individuals, communities, and social structures. She notes that a single place can carry multiple meanings – and multiple histories, through remembered meanings – for different people at any one time. However, when people – even members of the same community or cultural group – have differing beliefs about the meaning, history, or value of a particular place, tensions and conflicts can arise (Zapf, 2009). When one group is in a position of power over others, the more powerful group’s beliefs about the meaning, significance, and role of place can influence the ways in which other groups experience, perceive, and relate to place over time. As human geographer Yi-Fu Tuan (1979) asserts, place is “a reality to be clarified and understood from the perspectives of the people who have given it meaning” (p. 387). However, recalling that a single place can hold different meanings for different people, it is also essential to consider whose voices are heard – and whose are not – when exploring the meaning of place.

In rural and remote practice, social workers will often imbue the landscape with their own meanings over time, through a process of coming-to-know that can eventually transform an unfamiliar space into a place that feels familiar and well-known (see Pierce, 2017). However, to engage in place-based social work, it is critical that the meaning(s) and significance of place also be explored from the perspectives of the people who call this place home.

Examples

Think of a place that is important to you now, or that was important to you at another time in your life. Take a moment and remember this place in as much detail as you can, with all of your senses. Then consider the following reflection questions:

- What experiences or traditions helped form your relationship to this place?
- How have people influenced this place throughout history?
- How has this place influenced you?
- If you wanted to share the meaning this place holds for you with another person, what activities or traditions might you invite them to take part in?
- If you wanted to share the meaning of this place with others, how might you go about it? Through photos? Stories? By inviting people to come and experience the place firsthand?

Implications of Place in Rural, Remote, and Northern Practice

To take up Zapf's (2009) challenge to develop social work practice that is rooted in place requires recognition of the myriad ways in which place and people are connected. With the intentional wording of "people *as* place," Zapf emphasizes the reciprocal relationships between people and the places they inhabit. These relationships are often particularly evident in rural, remote, and northern regions, where the rhythms of people's lives and livelihoods can be closely linked to local geography, weather and climate, seasonal changes, and the social, cultural, and economic opportunities afforded by the built and natural environment.

For social workers leaving an urban centre to work in a rural or remote location, the first indication of the significance of place may become clear during travel. For rural and remote residents, travelling longer distances to access services in a nearby town or city is commonplace. Depending on local climate, geography, and infrastructure, other barriers to travel may also exist beyond the length of the journey. Many remote and northern communities rely on several modes of transportation (boat, ferry, train, float plane, or helicopter) for part or all of the year, while some communities also have seasonal transportation options such as ice roads. Regardless of the type of transportation available, travel into and out of remote places is determined by changing weather conditions and the availability of daylight hours (shorter windows of daylight), which varies based on latitude and time of year.

While social workers may either enjoy remote travel or accept it as an inconvenient necessity of the job, travel can be an acutely determining force in rural and remote locations. The arrival of an all-weather road to a previously fly-in community, for example, may be hailed by some community members as an important step forward that increases access to "outside" services. Other community members, however, may feel any potential benefits are outweighed by the risks of increased access, such as the possibility of motor vehicle accidents along isolated stretches of road, and disruptions to local wildlife populations and traditional hunting or harvesting grounds. It is important to consider not only that local perceptions of remote place and travel may differ from urban expectations, but also that there is likely to be a diversity of opinions between communities and even among community members.

Physical infrastructure is another factor that contributes to the experience of place and the way social relationships are developed and maintained: Are there indoor community gathering spaces? Is there physical infrastructure to hold recreation programs for children and youth? Are there stores in the community that sell food and other essential items? The availability of resources to meet basic needs, such as safe housing and clean drinking water, is a significant aspect of physical infrastructure that has a direct influence upon people's health and well-being and affects experiences of living in place. Access to education within local communities is also important. Without local access to education, children must commute elsewhere to attend school daily, and in many cases youth from rural and remote areas must relocate to larger urban centres to attend high school and post-secondary education. Faced with the prospect of leaving their homes and families behind to attend school, some youth choose not to attend at all. By contrast, some rural and remote communities face an exodus of young people who leave for higher education and training and choose to continue living elsewhere. This is particularly a concern for rural agricultural communities, where young people are choosing to seek employment elsewhere rather than take over family farms that have traditionally been passed down to the next generation (Pletsch et al., 2012).

Economic opportunities and the resulting impacts upon people's livelihoods and daily and seasonal rhythms can be closely tied to geography, climate, and the natural resources available around the community. Rural agricultural communities have seasonal rhythms of planting and harvest that often shape community events and can lead to shared values and ways of living. The impacts of severe weather events such as flooding or drought, cases of insect infestations or livestock disease, or economic shifts, can have devastating impacts on entire communities. For example, the 2003 discovery of bovine spongiform encephalopathy (BSE), or mad cow disease, in Canada brought severe financial hardship to many farming families as well as businesses that relied on the agricultural community to fuel the local economy (Pletsch et al., 2012). Many farmers and their families also experienced negative effects upon their mental and physical health, due to financial stress and – for some – the loss of connection to place and to a way of life for those who had to sell their farms (Pletsch et al., 2012).

Some rural and remote communities have economies based in natural resource extraction, management, or development projects, such as mining, forestry, oil and gas, and hydroelectric dam construction. Such projects can be highly contentious, in no small part because of their potential to have long-lasting impacts upon people and place. Economically, natural resource industries and "industry towns" are often characterized by boom-and-bust cycles, where communities can see an enormous influx of workers and rapid local economic growth, followed by "bust" periods that at their most extreme can result in ghost towns, or places mostly abandoned due to a reduction in economic activity. For people in remote communities who may otherwise have few potential job

options close to home, the opportunity to participate in nearby industry activities is attractive. At the same time, resource projects across the country have raised social justice concerns. Racialized people and people with low socio-economic status are disproportionately influenced by the environmental effects of industrial waste and agricultural pollution (Bay, 2014) and Indigenous women and girls in particular have been affected by the influx of (often male) workers arriving at work sites in rural and remote areas (Women's Earth Alliance & Native Youth Sexual Health Network, 2016). Chief Bernard Ominayak, writing about the effects of resource exploitation upon the Lubicon Lake people of northern Alberta, describes that "[t]he benefits of resource exploitation in our traditional territory flow to outsiders. Yet the full impacts of those decisions are felt here, by our people" (Ominayak & Thomas, 2009, p. 112).

Finally, many people in rural, remote, and northern communities have social, cultural, and spiritual practices that are linked closely to place. While no two Indigenous communities are exactly alike, traditional Indigenous cultural values often include a belief in the importance of living in harmony with nature (Baskin, 2016). Indigenous communities that engage in traditional means of gathering food often have seasonal patterns of hunting, trapping, fishing, and harvesting that are responsive to the health and availability of local plants and wildlife. These patterns – which may include seasonal camps – can be an important contribution to food security in addition to strengthening cultural, spiritual, and social connections among community members and with the land.

Collier (2006), when discussing the influence of economic factors in rural and remote communities, suggests that behaviours that would seem odd through an urban lens often make perfect sense in the context of local rural knowledge, values, and beliefs. It is consequently important for social workers – regardless of whether or not they are coming from an urban background – to contextualize their observations and (importantly) explore the meanings held by community members about the places they live, the ways in which they travel, and the influence of economy and infrastructure in their lives.

Land and Indigenous Peoples

As noted earlier, power can play a role in determining how places are perceived and experienced. With power comes the potential for dominant groups to impose their views of place upon others. Māori scholar Linda Tuhiwai Smith (2012), for example, writes that the impacts of Western colonization in Aotearoa/New Zealand have not only altered physical landscapes but have also affected the ways in which Indigenous people relate to the places and spaces around them. She describes that

> For the indigenous [*sic*] world, Western conceptions of space, of arrangements and display, of the relationship between people and the landscape, of culture as an object of study, have meant that not only has the indigenous world been represented in particular ways back to the West, but the indigenous world view, the land and the people, have been radically transformed […]. In other words, indigenous space has been colonized. (p. 53)

Colonization in Canada is also rooted in the issue of land (Baskin, 2016; Kennedy-Kish et al., 2017; King, 2013), and although the colonization of Indigenous space in Canada began well before the advent of social work, social workers have a long history of involvement in settler-colonial processes. In removing Indigenous children from their families and communities, first in concert with the residential school system and then increasingly through the "60s scoop" (Blackstock, 2009), social workers displaced these children from the places they called home (Kennedy-Kish et al., 2017). Even now – and often despite the best efforts of social workers, family members, and other caregivers – Indigenous children in foster care continue to experience not only the loss of connection to their family, culture, and community, but also the loss of physical belonging to land and place. A recent report by the B.C. Representative for Children and Youth (2021) shares the story of a young Dene girl named Skye who died while in foster care in 2017. Her story is sadly similar to that of Richard Cardinal, a Metis child who also died in foster care in 1984. Living in multiple foster homes throughout their childhoods, both children expressed a desire to return to the places they were from or where they had experienced a sense of belonging (Obomsawin, 1986; Representative for Children and Youth, 2021). Neither child was able to return home until after their death (Obomsawin, 1986; Representative for Children and Youth, 2021).

As social workers responsible for children – Indigenous and non-Indigenous – it is imperative to consider the importance of attachment to place. While it is not always possible to place children in foster homes within their home communities, efforts can be made to consider the impacts of displacement and to find ways to support experiences of physical belonging both through visits home and through experiences of belonging and connection in other ways.

For social workers practicing anywhere in Canada, it is critical to foster an awareness of the history of the lands we practice upon (see learning/activity box below), the implications of this history for the people we work with, and the dynamics of power and

place that continue to define the landscape and shape interactions between people and place.

Examples

- What is the history of the land where you practice?
- Whose place is it?
- What brought you to this place?
- How do you relate to this place?

Practicing in Place

In response to Zapf's (2009) call for social workers to incorporate a metaphor of "people as place" as a foundation for practice, this chapter has outlined "place" as both a location in space and the meaning attributed to this location. Place – including the natural and built environment – is consequential for the lives and livelihoods of people in rural, remote, and northern regions. As a dynamic and relational concept, place has the potential to evolve, hold distinct meanings for diverse people, and both influence and be changed by power and politics. Grounded in an understanding of place as dynamic, relational, and defined by the people who live there, what might it look like to integrate a model of "people as place" into rural, remote, and northern practice? This section explores ways in which social workers experience, interact with, make, and practice in place.

Brian Cheers (2004), an Australian social work scholar, describes his experience of rural practice as an active, ongoing process. In his words,

> I, *and you*, bring to the conversation my, *and your*, particular place. It is the only one there is. It is an open, dynamic mosaic; a place where lives, livelihoods, environment, culture, and governance meet; a place where community, services, policy, and professional narratives intersect. Things happen in places.
>
> But I haven't come here dragging my place behind me – kicking and barking like some bewildered cattle dog on a sheep station. It lives through me. I *make* the space I live in *my place* by giving it meaning as I go about my daily living. The rural practitioner does not sit outside, mysteriously materializing in the space of the community to, just as mysteriously, disappear back to some well-ordered, comfortable, well-to-do planet of professionals when their day's work is done.
>
> If my place is unique, then so, too, is my practice. I invent it as I go along. I don't *do* my practice – I *make* it in places. (p. 9)

In this excerpt, Cheers captures multiple important elements of practicing in place, providing a solid basis for imagining what a practice of "people as place" might look like and developing place-based principles of practice in rural and remote practice. This section focuses on each of these elements in turn.

Reflective Practice

Social work students are commonly asked to reflect upon their personal positioning, or social location, in relation to social constructs such as race, gender, and socio-economic status. Less often are they urged to consider the intersection of their social location with the physical spaces they inhabit. As Cheers (2004) observes, "I, *and you*, bring to the conversation my, *and your*, particular place" (p. 9). Social workers and service users alike carry personal and collective experiences of space and place that shape their beliefs and influence their interactions with the world around them. As social workers, it is worth reflecting upon the convergence of "particular places" that are brought together through social interactions. In these interactions, whose experiences and ways of being in place are prioritized? Knowledge is created in places (de Leeuw & Hunt, 2018) and engaging in reflective place-based practice requires consideration of where knowledge came from, as well as how experiences of place contribute to different worldviews.

Space and Place

At the core of place-based practice is a willingness to acknowledge and explore space and place in order to inform approaches that are relevant and responsive to local context. As Cheers (2004, p. 9) observes, "[t]hings happen in places"; and yet, social systems and relationships are too often removed from the spaces and places where they occur. By recognizing that social realities are constantly unfolding in places, social workers can gain greater insight into the strengths, challenges, and relationships of people, communities, and systems, ultimately supporting the development of holistic solutions to social problems. As factors that influence

well-being and play a role in social interactions, space and place can influence power dynamics, relationships, and the likelihood that people will feel comfortable seeking support from a social worker in their community. Recalling that places are dynamic, relational, and defined by the people who live there, it is important not just to develop a static understanding of place, but to engage in a continuous process of exploring the significance of spaces and places.

Place-Making as Process

Cheers remarks upon the process of place-creation as he states that "I *make* the space I live in *my place* by giving it meaning as I go about my daily living" (2004, p. 9). People make spaces into places through interaction and relationships over time, a process that holds particular importance for social workers arriving in rural, remote, or northern communities for the first time. For example, Pierce (2017) recounts the experience of a social worker who came to a remote place and, through being open to and engaging in the process of being in place, learned that

> [p]eople here need to know you so they can place you within the community. It's a real collective way of knowing and being. People here know who to go to for specific things, such as, guidance, or fishing, so for me to work effectively, people here need to understand how I fit in their place. (p. 157)

This example of a place-based practice shows the process of a social worker beginning to make her practice in place. Over time, a place-based focus meant this social worker felt she was able to understand the meaning of her work and bond with her particular place. Simultaneously, the community was also engaging with the social worker to place her within the existing context of their place, highlighting the influence place has on practice.

In addition to developing a personal sense of place over time, social workers can also engage in collaborative processes of place-making with the people they work with. Cultivating a sense of place through shared experiences may not only assist social workers in developing a better sense of the meaning of place for the people who live there, but also form part of social work practice and interventions.

Creating Practice in Place

The excerpt from Cheers concludes with the assertion that "[i]f my place is unique, then so, too, is my practice. I invent it as I go along. I don't *do* my practice – I *make* it in places" (2004, p. 9). Indeed, just as people engage in continual processes of place-making over time as spaces take on new meaning, rural and remote social workers often create their practice through interactions and relationships over time. With an asset-based focus, building place-based practice often includes identifying, learning from, and contributing to existing helpers and systems of support within the community. In drawing upon available resources and allowing practice to emerge from what is needed, place-based practitioners are well-positioned to be responsive to local context.

Creating practice in place and being responsive to context also require an awareness of the closely woven and reciprocal relationships that are common in smaller communities. These relationships can lead to ripple effects, as captured in the following reflection by a social worker doing place-based work:

> You get to work with people in different ways and things are way slower paced; it's beautiful here. It is kind of like if you pictured a beautiful big spider's web sparkling in the sunshine. Each thread is extremely fragile on its own and sparkles in its own way, but each thread is also connected to another thread which is connected to the larger structure which makes it strong. The web has been built in a specific place that has meaning to why it is there. Equally, if you damage one thread, the entire structure is compromised. You have to practice thinking about all those pieces with each decision you make. (as cited in Pierce, 2017, p. 119)

These ripple effects – described by this social worker as a spider's web – highlight the imperative of attending to the context of people and place or, as Cheers writes, when "making practice" in rural, remote, and northern communities.

Conclusion

Zapf (2009) encourages social workers to consider the fundamental interconnectedness of people and their physical environments through a metaphor of "people as place." For rural, remote, and northern social workers who are interested in this metaphor, the next step is apply it to practice. However, neither making place nor creating practice are goals to be achieved; both are ongoing

processes of coming to know and learning to be in a place in ways that promote personal and community well-being. Pierce (2017) writes that none of the remote and northern social workers in her study could indicate a specific moment at which they suddenly knew or understood place-situated practice that resulted in their wanting to stay; rather, it was only by reflecting upon their process of being in place and then narrating this process that they realized it was multiple exchanges, experiences, and moments that contributed to their coming to stay in place.

Place-based practice in rural, remote, and northern communities is necessarily as diverse as the people who call – and make – these places home. There is no simple, one-step, quick, or easy guide to practicing in rural, remote, and northern places, just as there is no single approach to effective social work practice in urban areas. Although the idea of "creating" practice in place may seem daunting, it also holds the potential to be a fascinating and deeply meaningful experience.

Whether returning home or entering a rural, remote, or northern place for the first time, most social workers arrive equipped with the foundational skills and knowledge needed to build their practice. What if social workers also arrived equipped with skills of place-based reflection, an awareness of and openness to process, and a keen interest in the meanings of place held by the people and communities they worked with? Learning to be in place and to engage in place-based practice may be one way for social workers to experience not only working, but also living and thriving, in rural, remote, and northern communities.

Activities and Assignments

Although developing a relationship with people and place – and subsequently engaging in place-based practice – is a personal experience that can vary widely between practitioners and locales, it can be helpful to connect with other social workers engaged in similar work. Connections can take place by bringing together social workers in a community of practice, or by seeking supervision or mentorship from a social worker with significant experience in – and if possible, a passion for – rural, remote, and northern practice.

- What do you think would be your preferred form(s) of support if you were to work in a rural, remote, or northern community?
- How would you go about finding these social workers? What existing networks could you use?
- What initial questions might you have for a rural, remote, or northern social work mentor? How could you explore these questions now?

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Understanding and Supporting Immigrants and New International Arrivants in Rural and Northern Communities

10

Judy White

The focus of this chapter is on the changing landscape of rural and northern communities in Canada as a result of newcomer settlement in these locations; and on the role of social work in responding to the diverse challenges and opportunities facing these newcomer populations and their receiving communities. The definition of rural and northern being used includes both distance away from the cities or urban centres (spatial) as well as population size of communities (Johnston, 2020; Laurin et al., 2020). The terms settler and immigrant settler are used interchangeably to refer to newcomers who have moved to Canada from other countries. The term “settler” is intentionally used to push readers to keep Canada’s history of colonialism uppermost in mind during the discussions about newcomers in Canada. The chapter recognizes the presence of diasporic peoples who may have once arrived as immigrants but who are now settled as Canadian citizens, and for whom the term “immigrant” is no longer appropriate. This chapter also includes a focus on individuals arriving as refugees who are also seen as newcomers settling in Canada. The chapter recognizes the diverse ways in which newcomers or settlers are able to enter the country (Government of Canada, 2021). The list of pathways includes:

1. Express entry (applications are reviewed based on three economic immigration programs: the Federal Skilled Worker, the Federal Skilled Trades Program, and the Canadian Experience Class).
2. Family sponsorship
3. Provincial Nominee Program
4. Quebec-selected skilled workers
5. Atlantic immigration pilot
6. Caregivers Program
7. Start-up Visa (opportunities to start a business or create jobs)
8. Self Employment Program
9. Rural and Northern Immigration Pilot: (several communities in Alberta, British Columbia, Manitoba, Ontario, and Saskatchewan are participating in this pilot).
10. Agri-Food Pilot (opportunities to work in agri-food industries and jobs)
11. Health-care workers permanent residence pathway
12. Temporary resident to permanent resident pathway
13. Permanent residence pathways for Hong Kong residents

In addition to the above, individuals applying as refugees may qualify for entry under the Economic Mobility Pathways Pilot (Government of Canada, n.d.).

The next sections of this chapter will include a brief historical overview of Canada’s newcomer settlement history, followed by a discussion about the implications for social work practice. The discussions on implications for social work practice emphasize the importance of ensuring accessible and culturally relevant services; a focus on the importance of understanding and embracing cultural diversity; the importance of building trusting relationships; and the issue of newcomer settlement within the context of the Truth and Reconciliation Calls to Action.

The chapter emphasizes that social work practice in rural and northern areas offers an array of practice options for social workers: micro, mezzo, and macro because of the complexity of issues.

Learning Objectives

By the end of this chapter you will have had the opportunity to:

- Engage in critical reflection of newcomer settlement history in rural and northern Canada;
- Build knowledge of the complex, intersecting issues experienced by newcomer settlers in rural and northern areas; and
- Reflect on the implications for social work practice with newcomer settlers, in light of the Truth and Reconciliation Calls to Action (Truth and Reconciliation Commission of Canada, 2015).

Background

Immigrant/newcomer settlement in rural and northern Canada has survived despite the growth of industrialization and urbanization which led to the majority of immigrant settlers heading to larger centres such as Toronto, Vancouver, and Montreal (Patel et al., 2019). Provincial Nominee Programs (PNPs) and other policy and program developments have served to bolster settlement in smaller centres, northern, and rural communities across Canada, thereby increasing the diversity in terms of populations and needs. Newcomer settlement has had different impact on different groups of people and communities.

For Indigenous peoples, immigrant/newcomer settlement meant the loss of lands and long-lasting negative impacts on their food security, health and well-being. More specifically, loss of traditional lands resulted in loss of traditional ways of life and in a reliance on European foods (Hossain & Lamb, 2020; Robidoux & Mason, 2017). The long-term impact has been the emergence of physical and mental health challenges among Indigenous peoples in northern and rural communities (Hossain & Lamb, 2020). Indigenous peoples have continued to organize and engage in various strategies to address the historical impact. More recently, the Truth and Reconciliation Commission's Calls to Action exposed the history of genocide experienced by Indigenous peoples, and provided a comprehensive list of action items to which Canadians are called to respond (Truth and Reconciliation Commission of Canada, 2015).

While immigration policies resulted in losses for Indigenous peoples, they offered the promise of land and prosperity for settlers, many of whom left countries of origin because of economic and social conditions such as violence, poverty and lack of access to land ownership in those countries (Pedersen, 2004). Describing the evolution of immigration policy, Fleras (2014) summarized it as:

> *Patterns of immigration to Canada corresponded with the changing requirements of its economy. A pre-First World War concentration on agricultural development and domestication of the West gradually segued into a post-Second World War demand for unskilled labour to extract resources or stimulate industrial growth. More recently, emphasis has shifted towards a reliance on highly skilled immigrants as part of a master plan in transitioning towards a global/knowledge economy. (Reitz, 2003; Simmons, 2010, as cited in Fleras, 2014, p. 6)*

Many of Canada's aggressive immigration strategies developed in the 19th century even though settlers had been arriving long before this. The federal government's early immigration plan initially aimed at attracting White settlers from Britain and Northern Europe to fill labour market needs. The United States was also seen as a viable source country. The promise of employment in infrastructure development (for example, the rail industry) and in agricultural activity was an early attraction, especially in Western Canada (Friesen, 1987; Shepard, 1997). The emergence of settler clusters in rural communities was often facilitated by word of mouth or chain migration. Canada's ethnic and cultural diversity continued to grow because of the diversity among these settler populations.

Europeans originating from regions outside of Northern Europe experienced racist and discriminatory policies and practices during the early years of Canada's immigration outreach (Dobrowolsky, 2017). While these latter populations were not immediately welcomed, Canada eventually opened its doors to them. Consequently, a dominant White settler population emerged in rural Canada, with stories of classism, racism, and discrimination affecting these early settler populations in diverse ways, depending on country of origin. The "Whites Only" and/or Whites preferred policies are evidenced by policies, statements, and actions by a long list of Canadian leaders such as Mackenzie King, Wilfrid Laurier, and Robert Borden. Together, these leaders promoted anti-Black, anti-Asian, and other migration strategies and policies in order to limit or restrict settlement populations (Crawford-Holland, 2020; Dobrowolsky, 2017; Niergarth, 2010; Walker, 1985).

Despite the Whites only and/or preferred policies, non-White populations made their way to Canada's rural and northern communities, also because of the political, social, and economic conditions of source countries. Non-white settlers who were prepared to accept employment as farm or domestic workers were granted entry (Anwar, 2014; Silvera, 1989). Black Americans travelled from the Southern United States of America (USA) to Oklahoma, and then to Canada hoping to find a welcoming country that would offer land and opportunities for a better life (Crawford-Holland, 2020; Walker, 1985). Instead, they encountered a country where systemic racism was embedded within the cultural and social fabric of host communities. Notwithstanding, there are

examples of Black settlers setting up successful farms and homesteads in Prairie rural communities such as Amber Valley in Alberta, Maidstone in Saskatchewan, and Swan River in Manitoba (Irby, 1985; Johnsrude, 2004; Shepard, 1997). Canada's openly racist policies remained in place until 1967 when new immigration regulations were introduced.

The 1967 Immigration Points System introduced changes within immigration policy by placing emphasis on skills, education, and training rather than on factors such as race, ethnicity, and country of origin during the recruitment or screening stage (Anwar, 2014). This Points System reflected a movement away from a focus on agriculture and rural development towards urban development (Verbeeten, 2007). Canada's 1988 Multiculturalism Act was designed to move the country even further (Berry, 2013). Nevertheless, evolving policies and legislation did not result in the elimination of systemic racism. For example, while the Points System recognized the skills and backgrounds of applicants, this did not necessarily translate into jobs for all newcomers. Canada recruited the brightest and most gifted from developing countries but did not recognize their credentials and out of country work experience when they actually arrived in Canada. Racialized newcomers were often the victims of these discriminatory policies.

More changes were made when provincial nominee programs started emerging after 1998, leading to new immigrant settlement in smaller centres, rural, and northern communities. Nominee programs have provided opportunities for smaller provincial centres, northern, and rural communities to recruit newcomer settlers from varied social, economic, and cultural backgrounds (Bonikowska et al., 2017). Provinces and communities recruited individuals whom they considered to be best suited for their immediate, often short-term needs. Carter et al. (2010) suggest that provinces were usually able to attract newcomers with lower- level skills and/or with specific skill and trades backgrounds. These settlers might not have qualified under the federal skilled worker program. The Northern and Rural Immigration Pilot and the Agri-Food Pilot pathways were launched in 2019. These pathways have offered further opportunities for welcoming communities to attract newcomers to their locations.

Another significant pathway is the temporary foreign worker program which allows employers to hire temporary foreign workers when there are no Canadians available for the jobs. The program includes a focus on highly skilled professionals, seasonal agricultural workers, and domestic workers. The stories of exploitation and abuse of temporary foreign workers are rampant and have been repeatedly raised (Barnetson et al., 2017; Bryan, 2019; Narushima & Sanchez, 2014; Salami et al., 2015). However, these same workers are often reluctant to rock the boat since their participation in the programs and the resultant income are a lifeline for source countries. Families and communities depend on remittances and workers are reluctant to speak out about poor work conditions.

Finally, communities in rural and northern Canada have experienced periods of economic boom and bust, with accompanying employment, economic, and population growth and decline (Dobson et al., 2014; Marchand, 2012). Newcomer settlers have taken advantage of periods of boom and have also experienced the effects of bust. This is particularly relevant to newcomers who moved to northern communities where mining has been occurring (Coderre-Proulx et al., 2016). The arrival, or parachuting in, of newcomers (including interprovincial and international migration) for employment purposes has had significant impact on local communities. In some situations, companies have made investments into local infrastructure, but this has been inconsistent. A study by the Canadian Research Institute for the Advancement of Women described some of the issues facing northern fly-in and fly-out communities (Leung et al., 2016). Many of these communities do not have year-round road access so often depend on air travel. Accommodation may be temporary or portable, and not appropriate for families who are often based elsewhere. In boom times, the arrival of workers and their families in the hub northern or rural communities that serve the mining sites, has resulted in booming opportunities and business for hotels, restaurants, transportation companies, and stores.

At the same time, boom has had other impacts such as skyrocketing rental and housing prices, and challenges for non-mining companies to find workers because these companies are unable to match the high salaries of the mining companies. Those residents who are not employed directly in the mining sector are disadvantaged by the lower wages and skyrocketing prices. Temporary foreign workers employed in the service sector outside of the mining sector are faced with low wages and often overcrowded accommodations. Some research has identified other issues such as women's vulnerability to violence and an increase in substance abuse issues. An issue that continues to be raised is the impact of mining on the environment, the impact on women and Indigenous communities in the north, and the extent to which dialogue and genuine consultation has been done to identify the impacts of developments on the lives of Indigenous and northern peoples.

The next section will discuss implications for social work practice. The overall message is that the stories and experiences of newcomer settlement are complex and varied. As such, the aim of the section is to encourage students to explore the diverse opportunities that are available to them to address the needs of newcomers in northern and rural communities.

Implications for Social Work Policy and Practice

Overall, stories of life in northern and rural communities offer accounts of tremendous generosity and hope but also provide insight into the extent to which location away from major centres (place/geography) has posed a variety of challenges for newcomer setters and residents in these communities (Burnett et al., 2020; Kulig & Williams, 2011; Patel et al., 2019; Reid, 2019). These challenges include isolation, and unequal access to affordable public transportation, social services, health, and education resources (particularly specialist services). In addition, systemic racism and discrimination continue to be a major issue in communities across Canada.

Social work with newcomer settlers in rural and northern communities therefore offers an array of possibilities for social work practice: direct social work practice, community development, research, advocacy, education, and social policy. The hope is that social workers will engage in practice to support immigrant/refugee/newcomer settlement in these communities, celebrate the strengths of rural and northern communities, and address the disparities experienced as a result of northern and/or rural living.

As noted earlier, immigrant settlement in northern and rural communities has been driven primarily by economic considerations, and by economic and political developments both within source countries and internally in Canada. Immigration patterns and experiences have also been shaped by the talents/expertise that settlers bring to Canada and by government immigrant selection policies (Bonikowska et al., 2017; Kolbe & Kayran, 2019). The end result for communities is the arrival of newcomers from diverse backgrounds including diverse ethno-cultural, professional, educational, language, and class backgrounds. These are important considerations when striving to understand rural and northern immigrant settlement in Canada. The considerations identified above are particularly significant when working to ensure that settlers are able to (1) create a sense of home in their new locations; (2) have access to job and education opportunities that genuinely recognize and credit the credentials, knowledge, and skills which they bring from other countries; (3) have access to culturally relevant and appropriate supports, resources, and services to enhance their settlement and retention in their new locations; and (4) have a sense of well-being that allows them to flourish. They are also relevant issues for social workers who strive to address issues holistically, and who recognize the layered, multidimensional aspects of issues.

Social workers are therefore challenged to remember that a “one size fits all” will not work for newcomer settlers in rural and northern communities. Newcomers may be highly skilled professionals working in the mining and scientific sectors, and they may also be low skilled workers working in lower skilled agricultural or service sector jobs. They may be highly skilled professionals having left situations of violence and extrema trauma. They may be taxi drivers with professional backgrounds who are working other jobs to support families here in Canada and in countries of origin. Social workers will need to develop the knowledge and skills to learn about and understand these diverse realities. As well, communities will need to engage in ongoing reflection, training, and capacity building in order to ensure they are appropriately responsive to the new populations. As discussed in the following sections, policymakers, advocates, and community workers in rural community will need to constantly review, transform, and develop services and resources to respond to the diverse needs of their new arrivants. Areas of concern and need include availability of resources and infrastructure, understanding and embracing cultural diversity, building trusting relationships, and the issue of social work in rural and northern communities in light of the Truth and Reconciliation Calls to Action.

Availability of Resources and Infrastructure

It is worth emphasizing that studies focusing on the retention of newcomer settlers (those arriving as immigrants and refugees) have consistently noted factors such as access to employment (facilitated by recognition of foreign credential and non-Canadian work experience), education, and cultural communities as strong influencers on decisions to remain in communities, or to relocate (Carter et al., 2010; Krahn et al., 2005). Patel et al. (2019)’s scoping review identified factors such as social inclusion, culturally-appropriate services, gender, and housing as distinct social determinants of health factors relevant to well-being in rural and northern communities. Newcomer status adds another layer to these intersecting factors.

More specifically, in addition to generic health and social services, access to formal settlement services (infrastructure) offering language assessment and training programs, employment readiness programs, and mentorship programs have also been identified (Carter et al., 2010; Krahn et al., 2005). Unfortunately, formal settlement infrastructure has not been consistently available in northern and rural areas. Formal infrastructure, which can be seen as sites offering a level of cultural safety, has provided venues where newcomers can reach out to other newcomers and service providers, access resources and support services, raise issues relevant to their settlement needs, and address some of the isolation that they tend to experience. Infrastructure that includes

newcomer information centres provides one-stop centres where newcomer immigrant settlers can begin to learn about what services and resources are available in communities. The Northern and Rural Immigration and the Agri-Food Pilots are programs that are well positioned to fill such gaps since they are expected to ensure the availability of settlement and mentoring opportunities for newcomers (Government of Canada, 2021). Many of these welcoming communities already serve as hubs and outreach centres for those living in small towns, on farms, and in other rural locations. The assumption is that these newcomer gateway projects will expand existing resources.

One area where social work intervention would be useful would be to advocate for the development of infrastructure and services that might be missing. This could include advocating for interpreter services for newcomers who are accessing health and education services. Those social workers interested in macro practice could play a leadership role in bringing together various stakeholders to facilitate discussions and research about the development of such services. Another area would be engaging in direct micro practice within settlement agencies, health care, and the schools that newcomer children would be attending. Various communities now have Settlement Worker in School programs (SW1S) as well as social workers who provide a range of referral, support and mentorship services relevant to newcomer children and their families. Finally, social workers in settlement agencies, health, education, and other sectors may choose to engage in group work practice. This would be particularly useful for women who are survivors of abuse and violence; and would be a site where education about issues of violence and abuse could occur. More than anything else, social workers need to have the relevant and appropriate competencies to work well with newcomer women and their families. The next section explores the wide range of personal values and ways of being that all players—-including newcomers, community residents, community workers, and social workers—bring to communities and the relevance of these to successful settlement of newcomers into rural communities.

Understanding and Embracing Cultural Diversity

Newcomers to Canada have tended to move to larger metropolitan centres. As a result, ethnic and cultural diversity of rural and northern communities has evolved at a slower pace than within larger centres. This has been changing over time because of immigration policies, and also because of the emergence of more employment and business opportunities in rural and northern communities. Nevertheless, newcomers are moving into rural and northern communities whose populations may be tightly knit because of longstanding history and well-established relationships (Herron et al., 2021). The same factors that have positive impacts may also include troublesome elements for these populations. Rural residents may have lived in communities for a long time and cultivated a community culture that is slow to change and accept new ideas and ways of being. This reluctance may be driven by a commitment to preserving what is perceived to be dominant, acceptable traditions and cultures.

Those individuals who do not “fit” into the mainstream may include those who are living in poverty, Indigenous peoples, racialized peoples, and gender diverse peoples. Newcomer settler /immigrant/refugee status adds another intersecting dimension, especially when the country of origin is that of a developing country, is not seen to be adequately “Western”, and where English or French (depending on the location) is not the dominant language. Settlement workers, sponsorship groups, and social workers are faced with the challenge of working together to create communities that are open to embracing diversity, equity, and inclusion. This includes facilitating conversations and activities with messages about how diversity will add richness to existing cultures and communities.

In short, newcomers are coming from diverse cultural backgrounds and are living both positive and challenging realities. A huge challenge is to avoid essentializing cultural identity. Essentialist views of identity view identity as singular, fixed and stereotypically applied without paying attention to diversity within cultures and nationalities (Zilliacus et al., 2017). In other situations, there is a tendency to exoticize people of different cultural backgrounds by an over-emphasis on dance, food, and dress (Zilliacus et al., 2017). Social workers are encouraged to engage in critical reflection of the meaning of cultural diversity in order to arrive at a place where they recognize the multiple, rich, evolving, and complex identities of individual newcomers.

Well-intentioned social workers who fail to acknowledge these complexities, add fuel to existing tendencies to demonize or degrade non-Western cultures. For example, lack of acceptance or understanding of non-Christian cultures may lead to Islamophobia. An assumption that Muslim women wearing head coverings are all living in situations of submission fails to recognize the diversity among Muslim women wearing head coverings. In addition, ignorance about the rich cultural heritage of newcomers from many developing countries may lead to patronizing and paternalistic approaches by settlement workers and sponsorship groups. These issues, while common across different geographies, may be particularly problematic in rural and remote regions. Outcomes of ignorance, assumptions of superiority of one culture and way of being over others, and a drive to maintain the

resulting status quo are reflected in racism and gender-based discrimination. These issues may be even more intensely felt in rural and northern communities because of geographic location as well as the size of the communities.

There are multiple, interconnected elements to be addressed when seeking to support newcomers in their new homelands, and particularly in northern and rural communities. At the same time, rural and northern communities have well-established traditions of caring for one another. Social workers and other community workers are encouraged to draw on these positive traditions, and play leadership roles in working in partnership with communities to build awareness of the strengths, contributions and complex realities of newcomers. In addition, it is vital that social workers continue to examine their own biases and assumptions throughout their social work careers in order to be part of a process that has positive outcomes for newcomers in rural and northern communities. These actions will go a long way to build trusting relationships that are central to healthy communities.

Building Trusting Relationships

Several studies and reports have exposed the extent to which xenophobia, racism, gender-based discrimination and lack of cultural safety permeate the fabric of rural and northern Canada; and the extent to which these factors have had extensive negative impact on the well-being of communities (Du Mont & Forte, 2016; Higginbottom et al., 2016; Patel et al., 2019; Tungohan, 2017). Higginbottom and others have described how language barriers compromise accessibility to health services. They have also cited examples of newcomer women not understanding the concept of consent or not having faith in service providers' respect for confidentiality. They comment that newcomer women have not always been able to develop trust and build relationships with service providers because the sessions and processes, including communication styles, are often too fast paced. This results in service users not always understanding or trusting the proposed plans or interventions.

Social workers and other service providers will need to be continually aware of the need to improve their communication skills. This includes paying attention to the pace at which messages are communicated, ensuring the availability of brochures, pamphlets, and messages in multiple languages, and the availability of interpreters and cultural brokers. Of particular note to younger practitioners is to remember to slow down the pace of their speech, without sounding patronizing.

Social workers have a responsibility to ensure that services are relevant and accessible, and that they are able to provide the kinds of services that newcomers will access. Attending workshops and training opportunities to build competency skills will be helpful in building/enhancing communication competency skills for working with newcomers. Engaging in volunteer activities with newcomers in communities and within agencies will serve to build relationships and create visibility and messages of genuine interest and caring to newcomers. These kinds of initiatives will address the longstanding concerns that newcomers do not access mental health support services, even when there are concerns about the need to respond to histories of trauma and the impact on mental health and well-being.

Newcomers in rural and northern communities ought to have access to resources and services similar to those available to residents of larger, urban centres. Social workers and other health care providers recognize the issues of trauma and the accounts of mental illness experienced by many newcomers. However, they are still not always able to provide care because of varied cultural understandings and interpretations of mental illness, which often result in newcomers not accessing services. Other factors include the lack of familiarity with Western models of mental health services, lack of faith in the ability of service providers to respond to their needs, and the issue of stigma associated with mental health. That is, many of the health care needs experienced in urban centres are also prevalent in rural and northern areas. However, communities are now faced with the additional challenge of ensuring the availability of professionals who have the relevant competency skills to work with these diverse newcomer populations.

Technology plays a role in accommodating some of the disparities resulting from geographic distance away from main centres for all citizens. The COVID-19 pandemic highlighted the role of technology such as tele-health and e-health services, and social media tools particularly in rural and northern communities. It also exposed disparities when residents in rural and northern communities experienced unequal access to these same resources and services because of lack of adequate technology infrastructure (bandwidth as an example), and unequal financial resources to access this infrastructure. These are broad issues with which social workers can also be involved.

The above discussions have focused primarily on the role of communities and social workers in providing a welcoming place to newcomers who are arriving from other countries and settling in Canada's rural and northern regions. Newcomers continue to arrive in Canada at a time when Canadians are grappling with the histories of exclusion, colonization, trauma, genocide, and

violence experienced by Indigenous peoples in their own traditional lands. The next section of this chapter emphasizes that ethical social work practice in rural and northern communities requires that social workers learn about the histories of Indigenous peoples, and engage in practice that is grounded in principles of social justice.

Social Work in Rural and Northern Communities within the Context of the Truth and Reconciliation Calls to Action

One of the points raised in the introduction of this chapter is about Canada's colonial history with Indigenous peoples. The chapter began by noting the loss of land and culture, and the violence experienced by Indigenous peoples. This final section will draw on the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) to discuss the role of social work in rural and northern communities within the context of the Truth and Reconciliation Calls to Action (United Nations, 2008). UNDRIP challenges the doctrine of racism and expresses condemnation for the historic injustices suffered during Canada's colonial rule. The document names the loss of land and resources and applauds the pathways adopted by Indigenous peoples to organize in order to end all forms of discrimination and oppression. It also calls on states to provide prevention measures and redress in response to the colonial history. That is, UNDRIP makes a strong case for social justice. UNDRIP's declaration of the inherent rights of Indigenous peoples is well aligned with the Social Work Code of Ethics and particularly well synced with value 1: Respect for Inherent Dignity and Worth of People, value 2: Pursuit of Social Justice, and value 3: Service to Humanity. The door is open to social workers engaged with newcomers in rural and northern communities to work with newcomers so that they are immediately engaged in learning about and reflecting on Canada's colonial history and about the Truth and Reconciliation Commission's Calls to Action.

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) raises important questions about settler work in mining and extraction industries in particular. How has engagement with Indigenous peoples taken place? Have impact benefit agreements been developed in partnership with Indigenous peoples? (Amyot et al., 2012; Levac & Manning, 2019; Levac et al., 2016). UNDRIP also raises issues about the impact of all developments on the environment and the importance of proactive, consistent discussion with Indigenous people. That is, social workers have an opportunity to work with newcomer settlers so that they are engaged, as fully as possible, in new ways of being with Indigenous peoples. There should not be delay with these kinds of partnerships, teaching opportunities, and dialogue. Some concrete strategies for social workers include facilitating joint attendance at cultural, educational, and social events hosted by Indigenous peoples and newcomer settlers; development of joint social and community activities to build relationships and learn from one another; and facilitating events with attendees from a broad range of backgrounds, including Indigenous individuals and newcomer settlers.

Conclusion

The issues of newcomer settlement in Canada are complex and forever evolving. The pandemic (2019 and beyond) has added complicating factors since Canadians have been required to pay attention to social distancing, to vaccinations, and to doing everything to keep residents safe. This has created an additional burden on social workers who have traditionally worked hard on building human relationships through personal connecting. It has also created stress for communities where personal contacting has always been important. Clearly, technology and social media have helped to respond to the basic human need of connecting with one another. This chapter noted that the pandemic also exposed that not everyone has equal access to the full benefits of technology. This has certainly been the case for northern and rural communities, and will be an area to which policymakers and scientists will continue to attend. Social workers will also need to respond to concerns that not all older adults are comfortable with the use of technology. When immigrant status and language barriers experienced by newcomers are added to the mix, the concerns become more complicated.

The chapter has challenged social workers to understand and embrace cultural diversity and to avoid essentializing cultures and perpetuating assumptions of the superiority of one culture over another. The chapter recognizes the strengths of rural and northern communities and the different ways in which community is built. This includes the sites where community building and dialogue takes place (for example, seniors' centres, coffee shops and coffee rows, Legion centres, churches, and Elks Halls). The chapter concludes that social workers have a role to play to build bridges between newcomers, residents, and others connected to these locations.

The chapter identifies problematic issues that are present in communities. These include the experiences of temporary foreign workers whose contributions help to sustain communities, but whose experiences of precarity and exploitation are troublesome. These continue to occur at a time when communities are striving to set themselves up as welcoming communities. The chapter also

points to Canada's longstanding history of racism and to the importance of open discussion focused on unraveling root causes in order to address equity and inclusion.

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), along with the Truth and Reconciliation Calls to Action, together provide documents that social workers doing work with newcomers in rural communities can use to facilitate new ways of building relationships and working with Indigenous peoples and Canadian peoples. The documents can also provide important lessons about how to work with newcomer immigrants so that mistakes made with Indigenous peoples, are not repeated by immigrant settlement agencies.

Finally, this chapter recognizes over and over again, the complexities of issues and circumstances relevant to the lives of newcomer immigrant settlers. The chapter recognizes the multiple, intersecting identities of newcomers, and challenges social work students to dive deeper into these and other complex identities and experiences, for example: newcomers with disabilities, newcomers with diverse sexual orientations and gender identities, and newcomers at various life stages. Of particular note for further reflection is the situation of older racialized diasporic adults. These individuals would have come to Canada as immigrants or refugees but are now Canadian citizens. They may have lived as minorities in northern and rural communities for decades and continue to have strong connections to ancestral countries of origin. That is, doing solid, ethical practice with newcomers in Canada's rural and northern communities calls on social workers to push themselves to be open to the forever changing and complex realities and contexts of these arrivants, settlers, and communities.

Judy White is a Black woman who was born and raised in Trinidad and Tobago. Having been raised in a country with a long colonial history, Judy understands that independence did not lead to an immediate decolonial status. As such Judy's academic, practice, and community work has been informed by critical race and Black feminist theoretical frameworks; and by a deep commitment to decolonization and social justice. Most of Judy's early direct social work practice was carried out in rural Saskatchewan.

Activities and Assignments

- Students are encouraged to locate a settlement agency or immigrant gateway agency in a rural or northern region and discuss the services that are provided. What language supports are available? What services are offered? What is the geographic reach of the agency? What is the general profile of the newcomers they are seeing in their agency? What is the educational background of the workers? How did the community come to have a settlement agency?
- Choose a rural or northern community. What have been the newcomer settler trends over the past 5 years? What might be some of the emerging social issues? What have been the responses? What gaps in services exist? What have been the contributions of the newcomer settlers?
- Students are invited to review the list of communities participating in the Rural and Northern Immigration Pilot and the Agri-Food Pilot. Students are asked to choose two (2) communities to focus on. They are to develop a brief profile of these communities, identify the kinds of newcomer populations that are arriving, and highlight the potential community services that might be required.

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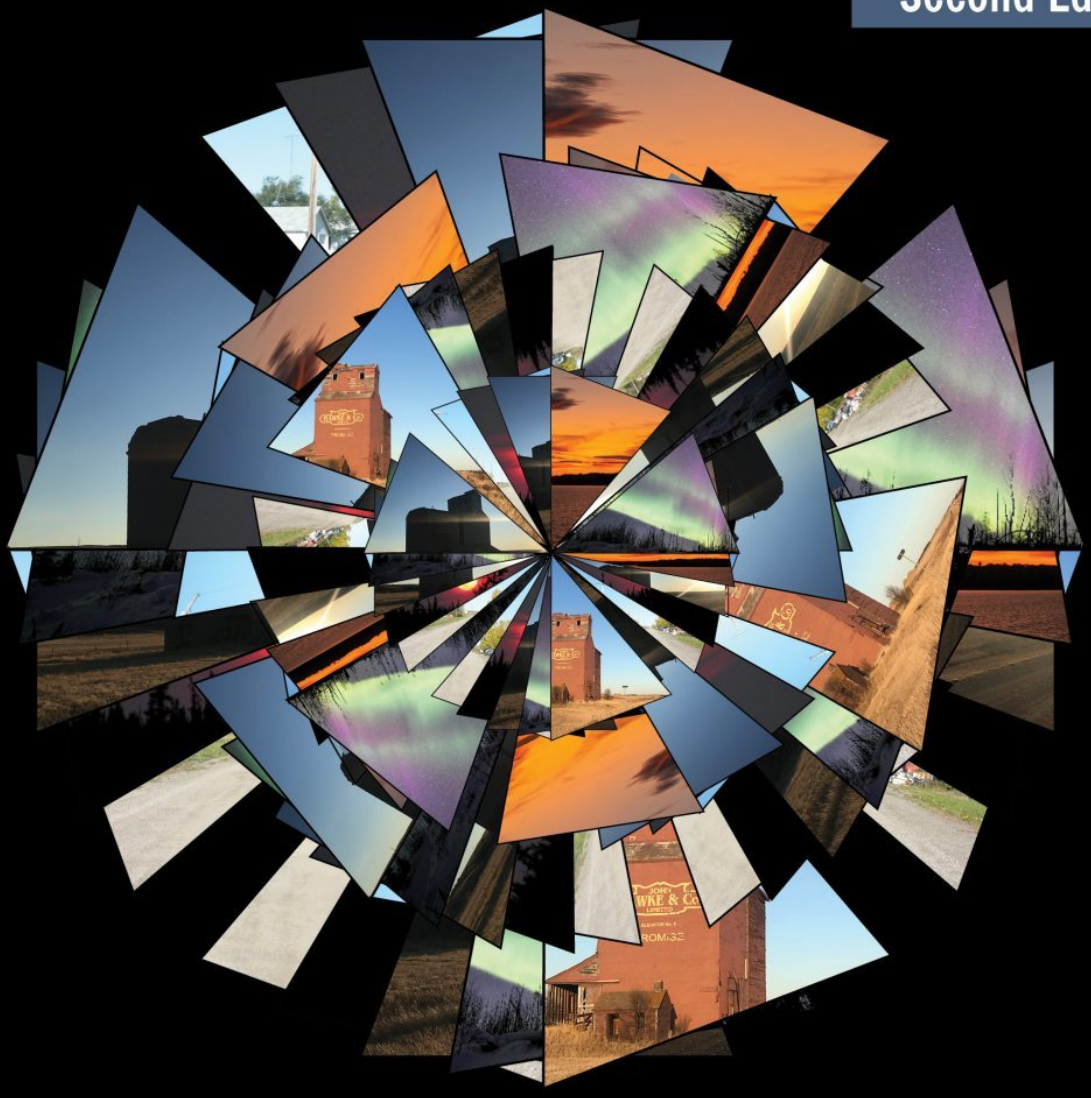
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Rural and Northern Social Work Practice:

Examples Within a Canadian Context

Second Edition

OPEN EDUCATIONAL RESOURCES



Bonnie Jeffery and Nuelle Novik (Eds.)

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Versioning History

3

This page provides a record of changes made to this toolkit. Each set of edits is acknowledged with a 1.00 increase in the version

number. The exported files for this toolkit reflect the most recent version.

Version	Date	Change	Details
1.00	November 28, 2022	Rural and Northern Social Work Practice: Canadian Perspectives textbook published in the University of Regina Pressbooks catalogue.	
1.00	December 15, 2022	Minor changes to comply with University of Regina guidelines	Changes to book cover to included logo and vertical side bar. Added Versioning History and Library and Archives Canada Cataloguing.
1.00	August 7, 2023	Typo corrections completed on page 10	Added accent to the ‘a’ in “Maori”
1.00	August 7, 2023	Typo corrections completed on page 23	Deleted extra ‘;’ from “(Applebaum, 2012; ; Badwall, 2013; Davis, 2016; Delpit, 2006;…”
1.00	August 7, 2023	Typo corrections completed on page 28	Deleted double ‘or’ from “If you are working for a decolonial institution or or have some decolonial actions in your practice, how might you maintain this?”
1.00	August 7, 2023	Typo corrections completed on page 28	Deleted extra apostrophe from “Jeffery, D. (2005). ‘What good is anti-racist social work if you can’t master it’?:…”
1.00	August 7, 2023	Typo corrections completed on page 28	Deleted extra ‘p’ and added a space in title of “McMahon, J., Borg, D., & Delaney, R. (2010). Anti-oppressive social work practice with AboriginalpPeoples…”
1.00	August 7, 2023	Typo corrections completed on page 33	Capitalized the ‘C’ for Christian in “My christian training took that away, and I always felt I was not good enough, not lovable enough, and that I would never amount to anything.”
1.00	August 7, 2023	Typo corrections completed on page 42	Added an ‘n’ to ‘an’ in “…people have a inherent right to a good life.”
1.00	August 7, 2023	Typo corrections completed on page 45	Capitalized the ‘C’ for Christian in “Standards for assessment are based upon white, western and christian worldviews which fail to consider cultural knowledges, values and beliefs.”
1.00	August 7, 2023	Typo corrections completed on page 47	Deleted extra comma from “as in where does counselling take place,,”
1.00	August 7, 2023	Typo corrections completed on page 55	Deleted the ‘n’ from ‘an’ in “an euro-western educated social worker and academic,”

1.00	August 7, 2023	Typo corrections completed on page 73	Added space between “northernCanada”
1.00	August 7, 2023	Typo corrections completed on page 85	Corrected “oxydone.” to “oxycodone.”
1.00	August 7, 2023	Typo corrections completed on page 96	Deleted extra period from “beliefs regarding intelligence, evolution, and violence..”
1.00	August 7, 2023	Typo corrections completed on page 102	Deleted extra space at the end of “trauma-and-violence information care practices can be used .”
1.00	August 7, 2023	Typo corrections completed on page 115	Deleted the apostrophe at the end of “Some research has been done into individual factors that may exacerbate some individuals’ risk over others’.”
1.00	August 7, 2023	Typo corrections completed on page 134	Decapitalized “Uncle”
1.00	August 7, 2023	Typo corrections completed on page 135	Added a line between “three week”
1.00	August 7, 2023	Typo corrections completed on page 148	Corrected “meso” to “mezzo”
1.00	August 7, 2023	Typo corrections completed on page 150	Corrected “meso” to “mezzo”
1.00	August 7, 2023	Typo corrections completed on page 151	Changed “is” to “are” in “Increased connection and support is key to increased”
1.00	August 7, 2023	Typo corrections completed on page 151	Corrected “meso” to “mezzo”
1.00	August 7, 2023	Typo corrections completed on page 163	Added a line between “long term”
1.00	August 7, 2023	Typo corrections completed on page 173	Added a line between “long lasting”
1.00	August 7, 2023	Typo corrections completed on page 174	Added a line between “short term”
1.00	August 7, 2023	Typo corrections completed on page 176	Deleted space between “Formal infrastructure , which can”
1.00	August 7, 2023	Typo corrections completed on page 177	Added a line between “gender based”
1.00	August 7, 2023	Typo corrections completed on page 178	Added a line between “gender based”
1.00	August 7, 2023	Typo corrections completed on page 184	Deleted the space between “agai nst”
1.00	August 7, 2023	Typo corrections completed on page 185	Deleted the space between “(Corbeil et al., 1983, as cited in Walker , 2002)”
1.00	August 7, 2023	Typo corrections completed on page	Deleted the space between “(IPV)”

		186	
1.00	August 7, 2023	Typo corrections completed on page 187	Deleted the space between “women (Daoud et al., 2013).”
1.00	August 7, 2023	Typo corrections completed on page 189	Deleted the space between “experiences of oppression , Murray et al.”
1.00	August 7, 2023	Typo corrections completed on page 189	Deleted the space between “violent the experience .”
1.00	August 7, 2023	Typo corrections completed on page 190	Deleted the space between “is not easily accessible .”
1.00	August 7, 2023	Typo corrections completed on page 192	Deleted the space between “within the community (communities served).”
1.00	August 7, 2023	Typo corrections completed on page 193	Changed comma to period after ‘etc’ in “(e.g. satellite offices, crisis hotlines, etc,)”
1.00	August 7, 2023	Typo corrections completed on page 196	Added the space between (Government of Canada, 2019).Psychological Abuse:”
1.00	August 7, 2023	Typo corrections completed on page 201	Added a line between “long term”
1.00	August 7, 2023	Typo corrections completed on page 201	Added a line between “to a person centered”
1.00	August 7, 2023	Typo corrections completed on page 214	Added a line between “long term”
1.00	August 7, 2023	Typo corrections completed on page 218	Corrected “*partia potestas” to “patria potestas”*
1.00	August 7, 2023	Typo corrections completed on page 220	Added a line between “in the close knit communities”
1.00	August 7, 2023	Typo corrections completed on page 220	Corrected “collaborative approaches” to “collaborative approach”
1.00	August 7, 2023	Typo corrections completed on page 223	Deleted the space between “(Durrant et al., 2017; Straus, 2001)”
1.00	August 7, 2023	Typo corrections completed on page 228	Added a line between “third party”
1.00	August 7, 2023	Typo corrections completed on page 235	Deleted the extra ‘the’ in “previously been on the the Royal College Regional Advisory Committee”
1.00	August 7, 2023	Typo corrections completed on page 235	Corrected “KIdsFirst Program” to “KidsFirst Program”
1.00	August 7, 2023	Typo corrections completed on page 237	Deleted the space between “(baby carriers)”
1.00	November 12, 2023	Typo corrections completed on page 20	Deleted “My master’s degree in public policy has made it more apparent how urban settings have governing power

			over rural locations. As an urban resident, I live with the privilege of increased autonomy compared to many rural communities attempt to have governing."
1.00	November 27, 2023	Typo corrections completed on page 32	Removed "to" between way and for.
1.00	November 27, 2023	Typo corrections completed on page 41	Corrected the title and note, changing "Severn" to "Seven".
1.00	November 27, 2023	Typo corrections completed on page 42	Corrected name of author cited. Citation should read "Absolon (2011)".
1.00	December 3, 2023	Typo corrections completed on page 225	Suggest that include the following addition in the case example entitled, Investigating Child Physical Abuse, first paragraph, last sentence: "I was taken aback by his argument and felt I could not respond adequately due to my own lack of knowledge of biblical text and having grown up in a non-Christian home."
1.00	December 3, 2023	Typo corrections completed on page 17	Provide an example of "rurally influenced cities".
1.00	December 3, 2023	Typo corrections completed on page 22	More recent citation added: (CIHI 2023; Pesut et al. 2022; Pugh et al., 2019).
1.00	December 3, 2023	Typo corrections completed on page 23	Updated statistics
1.00	December 3, 2023	Typo corrections completed on page 23	In the second full paragraph, replaced focuses with foci. In the last sentence of the last full paragraph, replaced foci with approaches.
1.00	December 4, 2023	Addressing BIPOC/ 2SLGBTQ+ of reviewer comments in Chapter 2.	
1.00	December 5, 2023	Typo corrections completed on page 76	Changed reference of Turtle Island from Canada to 'North America'.
1.00	December 5, 2023	Typo corrections completed on page 77	Changed reference of Turtle Island from Canada to 'North America'.
2.00	April 21, 2024	Typo corrections completed on page 155	Added "how" into "… outside of urban settings, and how to identify strategies to reduce that stigma."
2.00	April 21, 2024	Addressing BIPOC/ 2SLGBTQ+ of reviewer comments in Chapter 4.	
2.00	April 21, 2024	Addressing BIPOC/ 2SLGBTQ+ of reviewer comments in Chapter 6.	
2.00	April 22, 2024	Addressing positionality statement from reviewer comments in Chapter 2, 4, 5, 6, 7, 8, 9, 10, 11, 12 ,13.	Added positionality statements for each author and co-author at the end of the noted chapters.

2.00	May 30, 2024	Addressing reviewer comments and recommendation for Chapter 2	Whole chapter has been updated to reflect peer reviewed comments and recommendations
2.00	May 30, 2024	Addressing reviewer comments and recommendation for Chapter 8	Whole chapter has been updated to reflect peer reviewed comments and recommendations
2.00	May 31, 2024	Reference updated and typos corrected in Chapter 13	The new 2024 Canadian Association of Social Workers (CASW) *Code of Ethics* was added. The Riebschleger & Pierce (2018) reference was updated. The Burczycka (2018) reference was moved within the reference list.
2.00	June 6, 2024	Added section introductions for Section 1, 2, and 3	Brief introduction to each section added to section title page

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Women+ and Intimate Partner Violence in Rural, Remote and Northern Communities

11

Kristie Panchuk; Curtis Hart; and Dillon R. Lewchuk

In line with a feministic perspective the authors would like to recognize that there is no hierarchy in the contributive efforts of this chapter and acknowledge that this chapter would not have been possible without the differing intersectional perspectives of each author.

Violence against women is still prevalent in Canadian society and directly impacts not only women and their families, but also the collective community. In rural, remote, and northern communities across Canada, pre-existing vulnerabilities and risk of violence against women[1] is increased and often experienced through Intimate Partner Violence (IPV) and Domestic Violence (DV). The frequency of violence against women is a direct reflection of the ongoing social problems in Canada resulting in the inequality of women (e.g., historical, social, political, cultural, and economic, etc.). Conroy (2021) identifies that in 2019, the rates of family violence in remote and rural Canadian communities was 2.0 times higher than in the rest of Canada, and intimate partner violence was 1.8 times higher in rural and remote communities.

While these statistics are concerning, Gracia (2004) suggests that the majority of IPV and DV against women often goes unreported due to a multiplicity of societal oppression(s), personal circumstances, and barriers to accessing support. However, those who live with multiple intersectional ties may be at a higher risk of violence, particularly Indigenous, immigrant, and Lesbian/Bisexual/Transgender/Intersex (LBTI) women living in rural, remote, and northern regions (Calton et al., 2016; Daoud et al., 2013; Murshid & Bowen, 2018).

This chapter focuses on IPV against women in rural, remote, and northern regions. However, it should be noted that while women may also perpetuate violence, that will not be the focus of this chapter. Furthermore, it provides an opportunity to learn and reflect on the prevalence of IPV and DV in rural, remote, and northern communities within Canada and how social work practitioners support the work being done at the micro, mezzo, and macro levels. Social workers providing services in these communities need to be aware of risks, how to provide risk assessment, and how to incorporate safety considerations for those who may be experiencing IPV and DV.

[1] In this chapter the term “woman/women” refers to cisgender, trans, intersex, and anyone identifying as a “woman.”

Learning Objectives

By the end of this chapter, the following learning objectives should be achieved:

- Understanding of definitions of IPV and DV and awareness of the rates and the historical context for this issue in Canada, specifically in rural, remote and northern communities
- Awareness of implications for social workers working with victims of IPV and DV in rural, remote, and northern communities across Canada
- Understanding of specific safety planning and practice considerations for social work professionals on a micro, mezzo, and macro level
- Awareness of the importance for social workers to develop collaborative working relationships, and educational and advocacy opportunities to reduce the severity and frequency of IPV and DV occurrences.

Theoretical Framework

The complexity of violence and its impact may be best understood through a feminist, trauma-informed, intersectional lens. In alignment with a feminist perspective, this chapter uses the term “survivor,” rather than “victim,” as the word “victim” pathologizes and disempowers the woman who has experienced violence (Walker, 2002). Feminist theology serves to empower women and raise awareness that disparity and oppression within larger, structural, and political systems exist (Corbeil et al., 1983, as cited in Walker, 2002). In combination with a trauma-informed lens, principles grounding our understanding of domestic violence include the following: safety, trustworthiness and transparency, collaboration and peer support, empowerment, and choice for survivors (Bowen & Murshid, 2016). Applying these principles in understanding violence, in order to support survivors, highlights a useful approach to providing care that is not re-traumatizing. In addition, using an intersectional lens allows individuals to gain a deeper understanding of IPV and DV. For example, Sokoloff and Dupont (2005) explain that violence experienced and reflected among an

individual's social locators (e.g., culture) may be interpreted by the survivor differently than by witnesses or observers. Therefore, it is important to be aware that cultural differences should not mask the larger systemic and structural forms of oppression (e.g. racism, colonialism, sexism, heterosexism, ableism, patriarchy, economic exploitation, etc.) that impact and increase violence for women across diverse social locators (Sokoloff & Dupont, 2005).

History of Domestic Violence in Rural, Remote and Northern Communities

Canada is a vast country, with most of its population residing in large urban cities (Moffitt et al., 2020) and an estimated 19% of Canadians in rural and remote areas (Statistics Canada, as cited in Graham et al., 2017). Historically, the violence perpetrated against women has been embedded in many institutions and remains entrenched covertly and overtly in our current systems. For example, the women's suffrage movement and resistance against the dominant, patriarchal Canadian society began in Manitoba in 1916 (Parliament of Canada, n.d.). Other provinces, such as Saskatchewan and Alberta, followed suit until, on a federal platform, Canada conceded to the pressures of change (Parliament of Canada, n.d.). However, while there were a number of significant changes and rights acknowledged in the 20th century, violence against women continues to be a significant issue (Sitter, 2017). Walker (2002) highlights that during the 1970s, a network of shelters was developed across North America in response to violence against women (Government of Canada, 2021b).

Service Delivery

The delivery of safety services for survivors of IPV continues to be an area of advocacy research/development and ongoing evaluation for social workers in Canada. While DV does not differentiate among geographical locations, social workers working in rural, remote and northern areas of Canada have unique service delivery needs and limitations based on resources and location. The implementation of IPV policies that have been developed and implemented in more densely populated areas of Canada are often inadequate in meeting the needs of rural, remote, and northern communities.

Policy

Policy development for IPV and DV continues to be an area of concern, since several Canadian provinces lack legislation to support the survivors of violence. In 2021, six provinces (Alberta, Manitoba, Newfoundland and Labrador, Nova Scotia, Prince Edward Island and Saskatchewan) and three territories had implemented legislation to support survivors of IPV, in addition to the laws set forth in the Canadian *Criminal Code* (Government of Canada, 2021b). The *Criminal Code* is meant to prohibit some forms of IPV, including "physical and sexual assault, some forms of emotional/psychological abuse and neglect, and financial abuse" (Government of Canada, 2021a, para. 3); however, further support is required to address intimate partner violence (IPV) across Canada.

As part of the Canadian Advisory Council on the Status of Women's work conducted in 1980, there were key changes and suggestions made and implemented in the *Criminal Code* to address the issue of IP V at the time (Ad Hoc Federal-Provincial-Territorial Working Group, 2017). Other examples include an amendment in 1983 to protect partners in their intimate relationships from such acts as spousal rape, and in 1993 to include criminal harassment (i.e., stalking) (Government of Canada, 2021b). More recently,

> *…in June 2019, the Criminal Code was amended to strengthen the criminal justice's response to IPV, including by defining 'intimate partner' for all Criminal Code purposes and clarifying that the term includes a current or former spouse, common-law partner and dating partner. (Government of Canada, 2021b, para. 5)*

With that said, between 1974 and 2001, there was a 62% decrease of spousal homicides, suggesting that many of the changes had the desired effect (Ad Hoc Federal-Provincial-Territorial Working Group, 2017).

Provincial policymakers have continued to address the issue of IPV in provinces, such as in Saskatchewan where rates are above the national average, by developing legislation such as the *Interpersonal Violence Disclosure Protocol* "Clare's Law" (Government of Saskatchewan, 2021). First implemented in Britain in 2014, Clare's Law has been adopted, not only by the vast majority of municipal police in cities across Saskatchewan, but also more recently by the RCMP (Canadian Domestic Homicide Prevention Initiative, 2021; Government of Saskatchewan, 2021). With Clare's Law, an applicant can make a request regarding access to information about an individual's history and past criminal charges which may be disclosed by the proper authorities if they believe

that the person they are disclosing to is currently at risk (Canadian Domestic Homicide Prevention Initiative, 2021). These policy changes provide increased safety options for survivors of violence and promote choice and empowerment for survivors in collaboration with social workers and RCMP/police professionals.

The Impact of Domestic Violence

Not only is IPV and DV devastating for the survivor of the relationship, but its implications are also far reaching and may affect the entire family, particularly if children and/or adolescents are living in the family home. IPV also has impact on communities (large and small) and can be particularly devastating when combined with factors that further enhance the vulnerability of individuals and communities.

Childhood & Adolescence

As researchers, organizations and frontline staff who work with women and children who experience IPV and DV, there is an emphasis on interventions and prevention strategies. Cervantes and Sherman (2021) state that early exposure to violence in the home increases the chances that the cycle of violence will continue later in life for those children. Repeated witnessing of these behaviours normalizes this interaction, and children further learn this behaviour by imitating what they observe (Bandura, 1997). Therefore, exposure to violence in the home may increase a child's risk of expecting, engaging in, and tolerating violent behaviour in their own intimate relationships, thus continuing the cycle of violence intergenerationally (Cervantes & Sherman, 2021). The schemas developed by children and adolescents in terms of intimate relationships are often replicated, unless an individual is exposed to a new environment, which can then become a catalyst for change (Cervantes & Sherman, 2021). Martz et al. (2016) note that their research demonstrated that rural adolescents were at an increased risk for physical and sexual violence with their intimate partners, when compared to urban adolescents. This research is troubling as rural adolescents, and adults, have even less access to information, social supports, and formal services in their communities.

First Nations, Metis & Inuit Women

Colonialism has damaged and changed traditional cultural beliefs in First Nation, Metis and Inuit communities towards women. Daoud et al. (2013) note that before colonialism, women in these cultural communities held respected and valued roles, and it was unthinkable to engage in violence against women. Conroy (2021) identifies that due to historical and ongoing colonialism in Canada, IPV is a direct result of compounding factors such as residential schools, the 60s Scoop, the child welfare system, and murdered and missing Indigenous women. These factors can combine in creating intergenerational trauma, addiction, and poverty, as well as enforcing traditional, euro-centric, christian gender roles on Indigenous women (Daoud et al., 2013). Studies demonstrate that rates of violence are considerably higher among Indigenous women, especially in rural and remote areas in Canada (Brownridge, 2008) where Indigenous women experience IPV eight times more than non-Indigenous women (Daoud et al., 2013). In consideration of these disturbing statistics, Moreau (2019) notes that in 2017/2018 there were 522 domestic violence shelters across Canada, and only 30 of these shelters located on reserves. Daoud et al. (2013) argues that due to colonization, violence was introduced and still impacts the community in multiple ways. The first is through collective violence in the form of institutional discrimination that attacks human rights for Indigenous communities. The next is forcing patriarchal and Christian values onto Indigenous communities resulting in a shift in their gender roles and the balance of power among genders. The third distinction is a result of colonial policies, such as residential schools. Intergenerational trauma was perpetrated with the removal of children from their families, communities and culture, and the experience of abuse (physical/emotional/sexual/cultural) while in care. Intergenerational trauma from childhood experiences often results in family and intimate partner violence later in children's lives.

The violence continues to be so pervasive that campaigns, such as Amnesty International's *Stolen Sisters*, have been initiated to increase awareness around the higher rates of violence and discrimination perpetrated against First Nations women (Amnesty International, 2004). Statistics suggest that this group is six times more likely to be killed (Howard, 2021), and Oppal (2012) reported that First Nations, Metis, and Inuit women represent 10% of all female homicides, which is significantly disproportionate compared to the overall national crime rate against women.

Indigenous women living in remote, rural, and northern communities in Canada can also face significant barriers to leaving an abusive relationship, such as not wanting to leave one's family community or reserve (Campbell et al., 2003), limited or no access to a shelter, lack of support, and the cost of travel. These compounding challenges, combined with intergenerational trauma, contributes to ongoing colonialism in First Nations communities. Elders tell stories of the impact of colonization, the introduction

of alcohol and disease, and the mistreatment of women (Moffitt et al., 2020). According to the World Health Organization (WHO), alcohol consumption can further increase the risk for IPV. For example, excessive use of alcohol was identified as a risk factor for intimate partner homicide in 40% of cases reviewed in Ontario between 2003 and 2017 (Office of the Chief Coroner Province of Ontario, 2018).

Newcomers to Canada

Another vulnerable population to consider in rural, remote, and northern locations is newcomers to Canada. These women face further unique barriers when living in these regions, such as discrimination (e.g. racism), culture shock, communication (e.g. language) and immigration status (Ford-Gilboe et al., 2015; Murshid & Bowen, 2018; Sandberg, 2013; Sokoloff & Dupont, 2005). While many immigrant and refugee women experience barriers, these women are often dependent on their partners who perpetuate the abuse (Sandberg, 2013). This dependency may include financial dependency (education in other countries may not transfer), isolation from the cultural community, understanding IPV laws in Canada (Murshid & Bowen, 2018), lack of awareness of services (Ford-Gilboe et al., 2015), and the inability to leave the current home (Sandberg, 2013). The individuals perpetrating violence gain power and control by exploiting threats of deportation, reinforcement of patriarchal gender roles and relationships, and fear of losing custody of their children (Murshid & Bowen, 2018). Leaving the relationship is difficult due to discrimination experienced from a variety of sources including consideration of housing options and police involvement (Murshid & Bowen, 2018). Police may be under-educated or hold immigration bias/racist beliefs and may view the violence as a cultural attribute (Sokoloff & Dupont, 2005).

Lesbian, Bisexual, Transgender, and Intersex (LBTI) Women

One major unique barrier facing women in the Lesbian, Bisexual, Trans and Intersex (LBTI) community is a lack of knowledge and information possessed by service providers regarding LBTI issues and various forms of discrimination connected with this intersectionality. Kay and Jefferies (2010) explain that due to our heteronormative society, the classical definition and understanding of IPV is that a woman is harmed by a male. Furthermore, the two spirited, lesbian, gay, bi-sexual, transgender, queer, intersex and a-sexual plus (2SLGBTQIA+) community education around IPV is insufficient and 2SLGBTQIA+ individuals experiencing IPV may not classify their experiences as violence due to dominant cultural templates (Calton et al., 2016). Further, education in this area for professionals is severely lacking. Survivors seeking help may encounter further discrimination and stigma by law enforcement, the court system, and by helping professionals (e.g. homo/bi/transphobia), which may result in returning to their abuser and/or not reporting or seeking help for future occurrences (Calton et al., 2016; Sokoloff & Dupont, 2005). Renzetti (1998) notes the complexity that internalized homophobia plays as a contributing factor, as the survivor fears disclosing the violence. LBTI perpetrators of violence use internalized homophobia and the fear of discrimination by service providers and the community to gain more power and control over their partners (Sokoloff & Dupont, 2005). They often use the tactic of threatening to “out” their partner (Sokoloff & Dupont, 2005), and emphasize the potential risk of losing one’s children, employment, relationships (family/friends/community) or housing (Calton et al., 2016). Peterman and Dixon (2003) identified that if shelters are available for LBTI users, there is a unique risk that the perpetrator may enter the “safe” space (i.e. shelter) and commit further abuse and/or harass their partner. As well, service providers or residents at these shelters may be homo/bi/transphobic making them unsafe (Sokoloff & Dupont, 2005).

Barriers to Service Delivery

Due to the complexity and multilevel experiences of oppression, Murray et al. (2015) note that women often do not make an immediate decision to leave a violent partner/situation after a single incident; it is usually after gradual increases in violence that survivors make this decision. Furthermore, survivors of intimate partner violence and domestic violence will often leave and later return to their partner who perpetrated abuse multiple times before leaving for good (Murray et al., 2015). To begin understanding the barriers that face women living in rural, remote, and northern geographies experiencing IPV and DV, we suggest that social workers reflect on the four levels of oppression that are involved: societal/cultural, institutional, interpersonal, and personal.

Societal and Cultural

Sexism, patriarchy, Catholicism, racism and traditional “family values” still affect the lives of Canadian women. These oppressive ideologies often are more prominent and reinforced in rural communities. Wendt and Hornosty (2010) state that patriarchal attitudes, gender stereotypes, traditional family units, and traditional gender roles are interwoven with rural values. These large

oppressive structures and ideologies trickle down and reinforce violence against women which can make it difficult for them to leave abusive situations in rural, remote, and northern communities.

The impact of COVID-19 on IPV and DV situations has also added an additional layer of complexity for women. Women who were experiencing IPV/DV before and into the pandemic were further isolated from opportunities/resources as health orders for public safety iterated stay home orders and physical distancing. Fears of exposure to the virus, not being able to access shelters, and feeling the need to stay home with their partners prevented many survivors from reaching out during this time (Moffitt et al., 2020). Survivors who were already isolated due to geographical location had a decrease in chances that a neighbour might potentially overhear/witness or intervene during a violent episode (Sandberg, 2013), and a new barrier was thus created by the virus with the narrative that *isolation equals safety* (Moffitt et al., 2020). In addition, the impact of the pandemic with factors of higher stress levels on individuals and families (e.g., partners losing work, children's remote learning) led to increased risk for controlling behaviors and/or heightened barriers for accessing support (Moffitt et al., 2020).

Institutional

Women living in rural, remote, and northern communities face further oppression as the societal beliefs recur within institutions, and survivors encounter unique barriers due to the geographical location they reside in. Research shows that many rural communities pride themselves on "moral lifestyles," including the sanctity of marriage, family life, and Christian- centered values that serve as the foundation of their town. For example, the institution of marriage impacts survivors of IPV and DV; Cervantes and Sherman (2021) conclude that many women believe that the abuse they encounter is a consequence of marriage. This patriarchal belief instills in women the conviction that, due to their decision to marry ("for better or for worse"), they must endure the abuse no matter how violent the experience. Furthermore, Wendt and Hornosty (2010) comment that in rural life, masculine power and privilege is publicly visible. This privilege is often seen in farming organizations, bars, municipal governments, and sports teams. In terms of local municipal government, Edwards (2015) comments that in certain rural, remote and northern communities, individuals in power may hold the belief that IPV is non-existent and therefore less government involvement in providing preventative or crisis services is needed.

Women experiencing IPV and DV living in rural, remote, and northern locations face increased difficulty accessing services than their urban counterparts. These services may include daycare, community resources, law enforcement (Edwards, 2015), transportation, social services, courts, and shelters (Sandberg, 2013). Services are frequently lacking and limited due to lower population density than is needed to create or receive funding (Phillips & McLeroy, 2004), and the information regarding services is not easily accessible. If services are available, barriers may include issues related to privacy and anonymity, poverty (Edwards, 2015), lack of response from service providers due to long waitlists, being placed on a waitlist, difficulty getting information (Ford-Gilboe et al., 2015), and geographical isolation from community and social support (Sandberg, 2013). Sandberg (2013) notes that the often-low socioeconomic reality of isolated communities results in lack of infrastructure, poor road conditions, lack of job opportunities, and fewer voluntary supports. Regarding law enforcement, Websdale and Johnson (1997) found that rural law enforcement had longer wait times when called and individuals were lucky if police even showed up regarding DV situations. This delay in time-sensitive support and medical care in rural, remote, and northern communities results in increased risk of homicide, due the severity of the inflicted injuries (Gallup-Black, 2005). Additionally, specialized services ranging from police, lawyers, social supports, local courts, and judges often lacked specialized training in IPV and DV (Sandberg, 2013).

Interpersonal

Cervantes and Sherman (2021) identify that, within rural, remote and northern contexts, a commonly-held belief is that domestic violence is not a community problem/responsibility but a personal issue that should remain private. Cohen and Nisbetter (1994) emphasize that rural communities pride themselves on a "culture of honor" which stays quiet and accepts violence, especially if it puts a family's reputation at risk. This self-preservation at the community level, with the additional barriers of geographic location, makes it difficult for women to find support or resources. Dekeseredy and Schwartz (2009) identify that a safety risk more specific to rural communities occurs when the individual who perpetuates violence has high social capital and, as a result, the likelihood of the tight-knit community supporting the woman is low. Regarding safety, Sandberg (2013) comments that in rural life, conflicts of interest and anonymity are almost non-existent. Law enforcement, social workers, and medical professionals are likely to have a personal relationship with the individual who perpetuates abuse, and safe houses may be difficult to keep invisible from that individual.

Personal

Identity for rural women becomes a potential barrier to services, as Wendt and Hornosty (2010) state that many rural women who have a strong identity with the land, community, and preservation of the family may stay in abusive relationships longer due to internal conflict related to what they would potentially lose. The lifelong ties to the land on which many women have grown up is also what they depend on economically (farmland) and plan on pass down to future generations. In addition, the community element of feeling a sense of belonging and connection is also extremely important to many individuals living in small rural and remote communities. Communities in rural, remote, and northern regions are often close knit and depicted as a "rural idyll" (Harvey, 2009). Harvey (2009) defines this term as an ideal place that promotes and reinforces peace, health, home, and family. This term includes the concept that women hold the central role in families and communities. Lastly, the traditional role of the woman ensures the family's preservation and the moral expectation of self-sacrifice (Cervantes & Sherman, 2021). Wendt and Hornosty (2010) point out the reality of disclosing the abuse or exiting the situation most often results in the woman losing their economic investment (inherited family farm), family, and supports (shunned from community); survivors feel isolated starting over in another location, if that is even viable. Women experiencing abuse may also struggle with posttraumatic stress disorder and/or other mental health concerns (Tutty, 2015). More specifically, the impact of posttraumatic stress disorder and mental health struggles often leads to difficulty accessing social support (withdrawing), lowered self-esteem, and reduced problem-solving skills and advocacy for oneself (Beck et al., 2014). It is important to recognize that women experiencing IPV and DV, who then also experience mental health concerns, are often at an increased risk to return to the abusive relationship (Ford-Gilboe et al., 2015).

The severity of the violence experienced by women in rural, remote, and northern Canada is significantly elevated by the unique factors of isolated geographic locations and rural values. Martz et al. (2016) reports that due to isolated geography the high potential of increased economic poverty often magnifies the severity of IPV. Furthermore, economic dependency, in combination with the increased likelihood or possibility of the perpetrator being unemployed, or engaging in substance abuse, contributes to even higher rates of chronic and severe IPV (Edwards, 2015). Often, those who perpetrate violence may intentionally move their partner to an even more isolated area, away from their established social networks and communities (Dekeseredy & Schwartz, 2009). Finally, lack of access to reliable telephone and internet services, which is often the case outside of urban centres, serves to further enhance social isolation and hinder the ability to seek support services when needed (Moffitt et al., 2020).

Barriers to Support and the Cycle of Violence

It may take multiple attempts to leave an abusive relationship (Griffing et al., 2002) due to the multiplicity of barriers present and the immense difficulty of breaking the cycle of violence. Murray et al. (2015) reports that clinicians working with those attempting to leave abusive relationships call this moment the "window of opportunity." Khaw and Hardesty (2007) describe this opportunity as a "turning point" that redirects an individual's path and helps them move from one life stage to another. These turning points are vital for professionals to notice, and are the result of four distinct factors: severity of abuse (e.g., when the individual hits their breaking point), personal resources (e.g. financial independence), social influences (e.g., formal, and informal supports) and child-related influences (e.g. if it is perceived that the children are in danger) (Murray et al., 2015). Other external indicators are education on abuse, informing friends and family members about the past/current abuse, and empowering themselves (e.g. accessing employment opportunities, seeking counselling and other professional services) (Chang et al., 2006).

After Care Support Services

The focus of the helpers supporting the survivor is on their safety and wellbeing. Ford-Gilboe et al. (2015) argue that after the separation, women are in a period of time highlighted by increased potential danger, as a result of financial insecurity, lack of social support, and health risks (Ford-Gilboe et al., 2015), and retaliation by the perpetrator. Financial stress may include suddenly becoming a single parent, childcare costs, transportation costs, finding affordable housing, finding stable employment, or legal costs (Ford-Gilboe et al., 2015). Ford-Gilboe et al. (2015) comment that the lack of social support and health risks include starting over in a new community for safety but without familiarity and social supports, residue of emotional (mental health), and physical impacts (injuries) of the abuse. Finally, helpers should take into consideration that after women exit the violent relationship, the harassment and potential danger of further violence continues or escalates which increases the survivor's stress levels (Wuest, 2003).

Safety Planning and Assessment

The Ontario Domestic Assault Risk Assessment (ODARA) is a tool that has gained popularity across Canada over the past 10 years. It is the first empirically-tested and validated tool to assess risk of future domestic violence when an assault has already occurred in a relationship, as well as the frequency and severity of the assaults (Hilton et al., 2010). The ODARA asks thirteen questions and each question (historical, current abuse, access to firearms, and assault in pregnancy) reveals a score to look at rates of recidivism (Hilton et al., 2010). Being trained in, and working with, specific risk assessment tools is beneficial for a variety of reasons, including development of a collaborative understanding of the nature of the violence the client is experiencing. The ODARA is an assessment that is accessible for use by police, victim services, social workers, health care, and correctional agencies and enhancing evidence in court (Hilton et al., 2010). The ODARA specifically can inform a client of their overall level of risk, provide information and assistance in taking precautions, and contribute to a safety plan (Hilton et al., 2010).

The choice to leave one's home is often difficult for individuals who live in rural and remote areas, or for those who live on reserves (Moffitt, 2020) and may include unique obstacles such as the safety of pets or livestock. Research shows that many survivors have strong bonds with their pets (Barrett et al., 2018). However, having a cohesive safety planning template and assessment specific to challenges in rural, remote and northern communities is imperative to ensure continuity of services. Educating RCMP members, healthcare professionals, and community social workers on the cycle of violence, the nature of domestic violence and enhance wrap-around services to support survivors is essential.

While there are several risks that may elevate the potential and severity of violence, one of the most fatal considerations is the access to firearms. Firearms can become weapons of fear, control and violence in intimate partner relationships and studies have revealed that rural families are twice as likely to have access to a firearm and 2.5 times more likely to use a firearm to kill their partner (Banman, 2015). Of the rural, remote, and northern domestic homicides in Canada, 1 in 3 homicides were completed using firearms (Dawson et al., 2018). These types of risks require consideration of safety for the survivor, family and/or the social work practitioner when working in rural, remote, and northern communities.

Further Implications for Social Workers

Social workers working and/or living in rural, remote, and northern communities face unique challenges from their urban practicing counterparts. These factors often include the complexity of client needs without specialized services/specialized trainings (Moffitt et al., 2020), social workers filling multiple roles, lack of available and accessible services/resources (Sandberg, 2013), and the realities of isolation (Wuerch et al., 2019). Other impacts include constantly navigating dual roles with clients and within the community (Turbett, 2009), as well as the lack of anonymity and fearing the person perpetrating the violence may find out about the support given and retaliate against the professional (Ford-Gilboe et al., 2015). These challenges can contribute to a cycle of high turnover and professional burnout of social workers in rural and remote locations (Wuerch et al., 2019).

Micro, Mezzo & Macro Social Work Practice/ Service Delivery

Social workers working in rural, remote, and northern communities are often tasked with engaging in service delivery on multiple levels. Micro social work in communities focuses on engaging with individuals and groups in a therapeutic capacity. Mezzo social work involves a social worker developing and implementing initiatives at a small community level. Macro social work looks more specifically at helping large groups of people through research and policy advocacy and addressing prevalent issues within the community (communities served).

Micro

Social workers in rural, remote, and northern regions who want to create change at the micro level may intervene in diverse ways, such as creating awareness and educational support for individuals, addressing safety concerns, and supporting individuals in accessing services. Edwards (2015) identifies creating awareness of available services by identifying and advertising the services offered in each unique community (e.g. satellite offices, crisis hotlines, etc.). After the first step of creating the initial awareness of available support/services, social workers can support individuals in providing further education (about IPV/DV), pro-actively safety plan (considering all aspects) and help individuals navigate potential barriers to service.

Recommendations for professional practice include increasing anonymity and confidentiality, troubleshooting the lack of transportation, navigating shelters/transitioning houses/safe houses if available (Edwards, 2015), ensuring access to telephone and internet services (Fikowski & Moffitt, n.d.), and engaging in a collaborative process alongside other community services (Pruitt,

2008). Sokoloff and Dupont (2005) advocate for social workers to seek further specialized training when working with women experiencing IPV and DV. Social workers must engage in self-reflective practice so their work can be more effective and considerate of the intersectionalities of each client. Working within rural, remote and northern communities also requires self-reflection to ensure that confidentiality and safety implications and collaborative efforts can be maintained, while also reducing the risk of practitioner burn out.

Mezzo

Research indicates that the community can be a protective factor for women in relation to how the community understands, responds, and prevents IPV (Edwards et al., 2014). Edwards (2015) notes that communities can play a pivotal role in protecting the women in their community through raising awareness of intimate partner violence through public and community education. This awareness, education and coming together begin to shift the dominant harmful narratives in rural communities and may ripple into funding for more intimate partner violence services (volunteer and/or paid) (Edwards, 2015). Social workers can play a crucial role in the community through education, creating community understanding and raising awareness of the prevalence of intimate partner violence in rural, remote and northern communities to ensure that one's community becomes a protective factor rather than a barrier to accessing supports and services for survivors.

Macro

Rural, remote, and northern communities have varying needs and require voices from these communities to advocate for policy changes related to resource allocation and coordination. Improvements needed include specialized services, safety measures (e.g. shelters), and improved response times. As well, social workers can advocate for improving service response rates for protection orders and increasing resources and funding for IPV intervention and prevention efforts (Edwards, 2015).

Increasing access to affordable housing, transportation, financial security, childcare supports and culturally-appropriate resources is crucial in reducing barriers and stressors that lead to violence (Moffitt et al., 2020).

Finally, it is imperative for social workers and policy makers to work together to shift the cultural norms that support beliefs in traditional gender roles and patriarchy, as well as continuing to educate and increase knowledge about domestic violence, healthy relationships, sexual respect, and the impacts of substance use on families (Barton et al., 2015).

Ethical Considerations

There are a number of ethical considerations for social work practitioners working with survivors of intimate partner violence and domestic violence who practice in rural, remote and northern communities. There are several considerations that a social worker may need to be aware of, such as dual roles which may be defined as when "the social worker interacts in any capacity beyond the worker's professional role" (Dolgoff et al., 2009). Social workers must engage in reflexive practice regarding the power differential in their relationships. For example, the Canadian Association of Social Workers (CASW, 2005) *Code of Ethics* speaks directly about the "respect for the inherent dignity and worth of persons" (p. 4) which m ay become increasingly difficult when personal and professional boundaries are blurred (CASW, 2005). In smaller communities, this element can become particularly challenging because members are aware of the multiple roles, and attempt to elicit information, or the community may witness individuals at various social services locations. To provide effective services, social workers practicing in these areas should be cognizant of their boundaries and consider how to navigate their personal and professional lives.

The CASW *Code of Ethics* (2005) emphasizes the importance of confidentiality and privacy where trust is required for the safety of the client or community. For example, in smaller communities it may be possible that law enforcement or the social worker may be connected with the individual who perpetrated the violence; or anonymity becomes difficult for victims to access support services (Sandberg, 2013). Additionally, research suggests due to the potential lack of anonymity and availability of shelters (if any in or near the community), the perpetrator of violence may easily track down the victim decreasing immediate safety for the victim. (Sandberg, 2013).

As previously discussed, the concept of rurality and maintaining traditional ideals may contribute to further ethical considerations for social workers. Zerbe Enns (2014) highlights that a feminist approach to problems includes two themes, specifically "(1) the personal is political, and (2) problems and symptoms often arise as methods of coping with and surviving in oppressive circumstances" (p. 10). In relation to IPV, this type of perspective shift may be in drastic contrast for a community that may believe IPV is a personal rather than a communal, political, or structural matter.

Social workers practicing in these communities require the ability to be objective and differentiate between objective and subjective perspectives; they likely need to address their biases more frequently than their urban counterparts because of the dual roles they often have. A social worker must be aware of their personal values in relation to the CASW *Code of Ethics* as there may be competing values and they will need to ensure they are acting in the interest of the client.

Future Implications and Recommendations

In this chapter, we have outlined the importance of intersecting considerations (sex, orientation, ethnicity, rurality), and present challenges with respect to supporting survivors of intimate partner violence in rural, remote and northern communities. Further education, training (e.g., risk assessment), and collaboration between the community and professionals will be pivotal to reducing the impact of violence and the ripple effects in these communities.

Social workers working in these locations need to be cognizant of their own understanding of violence and engage in self-reflexive practice to identify what their community's needs are so they can advocate in the community and beyond, to stakeholders and policymakers, to cultivate change across all practice levels (micro, macro and mezzo). While this chapter has focused on IPV against women social workers and service providers must have an understanding that IPV and familial violence also impacts other populations (e.g. the 2SLGBTQIA+ communities and heterosexual, cisgender men).

Further recommendations for improving social work interventions and best practice include advocating for improved services in rural, remote, and northern communities to address the current shortage of shelters and support services in rural areas (Barton et al., 2015). To be effective, these services would benefit from addressing the challenges and risk factors specific to rural, remote, and northern communities. Multisector collaboration and coordinated community responses may also help reduce barriers to access in these communities (Eastman et al., 2007). "Wrap around" services for individuals such as shelter services, mental health services, financial support, childcare, housing and transportation support, and education/employment support may also be useful in response to the ever-changing needs of survivors (Eastman et al., 2007). Risk management and safety planning in rural, remote, and northern communities would also benefit from collaboration with police, healthcare, child welfare, victim services, and other social services that can help create a feasible, holistic action plan with the client (Ending Violence Association of B.C., 2021).

Lastly, as future research in this area of concern is conducted, Sandberg (2013) states that researchers should avoid creating a generalized narrative that rural, remote, and northern communities are places of violence. This generalization results in further marginalizing the individuals whom they aim to support (Sokoloff & Dupont, 2005). It is important to understand the oppressive social, colonial, and systemic structures in place that continue to disempower individuals, and to address this detrimental harm in further research, social work practice, and policies and strategies on reporting.

Conclusion

IPV and DV in remote, rural, and northern communities is a significant and ongoing issue. As a social worker working in rural, remote, and northern communities, one is more than likely to encounter IPV at some point during their career. Having a foundational knowledge of IPV, the historical context for DV, and the implications for social workers working with survivors in rural, remote, and northern communities is crucial. Working in collaboration with other professionals and at various practice levels to advocate for social and policy change is necessary to ensure the long-term safety of Canadian women. Further research on the impact and prevalence of women with disabilities and within the 2SLGBTQIA+ community in these geographical contexts will also be crucial in understanding the far-reaching impacts of IPV. Not only do social workers need to collaborate with community members, but federal, provincial, and territorial governments also must begin to work together to challenge the safety of women and vulnerable populations living in rural, remote, and northern communities.

Kristie Panchuk (she/her) is a Cisgender, Female, White Settler, Able-bodied, registered clinical social worker (SK)

Curtis Hart (he/him) is a queer, male, mixed ancestry, registered social worker (BC).

Dillion Lewchuk (he/him) is a queer, male, white settler, disabled, able-bodied, therapist (BC)

Activities and Assignments

In a small town (i.e. population under 700) located in northern Ontario, Sally lived with her partner, Maliki, her boyfriend of approximately 3 years. Sally is a 22-year-old female who worked part-time at the local grocery store until the birth of her son.

Maliki is a 42-year-old general labourer who struggles with maintaining employment and has issues with prescription medications due to a back injury which occurred in his late 20s. In his spare time, Maliki enjoys watching television, fishing, hunting, and knitting. During the first year of their relationship, Maliki had been working consistently; however, he lost his job, and his use of prescription medications increased. Sally then became pregnant. During Sally's pregnancy, Maliki became quite concerned about money and began controlling the household finances more strictly. When Sally needed money for groceries or bills, Maliki would allot her some cash, although this support often did not cover all the expenses. Financial pressures led to conflicts in their relationship.

When conflicts did arise in their relationship during the first year, there was no violence; however, Maliki would often begin to yell at Sally and then stop talking to her for days or weeks at a time. Then, Sally became pregnant and had a baby boy, Hannigan, who is currently 6-months. In her first trimester, Sally and Maliki had a disagreement and Sally began walking out of the house; Maliki slammed the door, catching Sally's fingers. The next day, Maliki apologized by taking Sally out for lunch and bringing her flowers. He promised that nothing like that would ever occur again.

As Sally's pregnancy progressed, Maliki became more concerned about finances and about the upcoming birth. For several months, there were no violent incidents but when Maliki would become angry, he started cleaning his firearms at the kitchen table which made Sally nervous. Sally had attempted to discuss her concern with Maliki, but these conversations often led to conflict; therefore, Sally has not brought up the issue again.

Please answer the following questions in relation to the above case study:

- What are some of the red flags present in this case study?
- With limited resources available in the community, how can you, as the social worker, create a safety plan with Sally?
- What ethical considerations will you need to reflect on?

Additional Resources

- Wuerch, M., Zorn, K., Juschka, D., & Hampton, M. (2019). Responding to intimate partner violence: Challenges faced among service providers in northern communities. *Journal of Interpersonal Violence*, *3*4(4), 691–711.

Types of Abuse
Physical Abuse: describes a range of physical contact intended to intimidate, inflict pain and/or bodily harm (Government of Canada, 2019). Psychological Abuse: describes a range of mental tactics to force, manipulate and or control an individual(s) (Government of Canada, 2019).
Sexual Abuse: describes involuntary and non-consensual sexual activity obtained either by threats or force (Government of Canada, 2019).
Financial Abuse: describes an individual's access to economic resources controlled by another individual resulting in forced dependence on the perpetrator (Government of Canada, 2019).
Neglect: describes a family member who is responsible for another individual but fails to provide basic needs (e.g. shelter, food, medical care, psychological, etc.) (Government of Canada, 2019).
Spiritual Abuse: describes abuse perpetrated by trusted spiritual practitioners and/or restrictions and defilement of sacred objects and/or ceremonial practices (Gray et al., 2021).
Criminal Harassment & Stalking: describes an individual who repeatedly follows, communicates and/or watches over an individual or an individual's home for the intent of power and control over a person (Canadian Resource Centre for Victims of Crime, 2011).
Cycle of Violence: describes the cyclical, repeating interaction between dichotomous behaviours of abuse and love; tension-building phase, acute/crisis phase and honeymoon phase (Sitter, 2017).
The Power and Control Wheel: describes the eight tactics (e.g. coercion/threats, intimidation, emotional abuse, isolation, minimizing/denying/blaming, male privilege, economic abuse) that abusers often use to gain power and control over their victim and which victims often don't associate as abuse (Cervantes & Sherman, 2021).

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