

BLI 2

Being Least Intrusive: An orientation to practice for front-line workers responding to older Indigenous adults experiencing abuse & neglect

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BC ASSOCIATION OF
Community Response Networks

Stopping Adult Abuse and Neglect ...Together.

Acknowledgements

The authors of the original BLI acknowledge with gratitude, humility and respect that we are settlers and uninvited guests on the ancestral and traditional territories of the Coast Salish, Kwakwaka'wakw, Liḡwítḡax^w, and Nuu-chah-nulth Peoples.

The development of this orientation has been enriched by the generous teaching and mentorship of many Indigenous elders and community members with whom we have worked over the years; we hold this guidance with profound appreciation.

In alignment with the principles of the BLI, we commit to the ongoing work of reconciliation - strengthening relationships of trust and collaboration between Indigenous and Non-Indigenous peoples and fostering environments of engagement that are culturally safe, inclusive and respectful.

Contributors to and supporters of the BLI

First Edition

BC Association of Community Response Networks (BCCRN)

Wit Works, Ltd.

VIHA, Home and Community Care Program, Campbell River (now Island Health, Community Health Services)

Kwakiutl District Council Health (KDC Health – now known as Liḡwitdax^w Health Society – LKT Health)

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Second Edition (2025-2026):

BC Association of Community Response Networks (BCCRN)

Wit Works, Ltd.

Island Health, Community Health Services, Campbell River

Squamish Nation, Xwi7ski Elders

Council for Reduction of Elder Abuse (CREA)

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Images

The images in this tool are plants used as medicine by Indigenous communities. The image of the feather is from Michelle Robinson 2026.

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Updated Scope of BLI

The BLI was originally developed to help front-line service providers, particularly those who are Non-Indigenous, orient themselves when responding to and engaging with vulnerable First Nation adults experiencing abuse, neglect, or self-neglect in on-reserve communities. Through its use, and through ongoing consultation with First Nation colleagues, healthcare leaders, front-line clinicians, community agencies, and other service partners, the scope of the tool has broadened in three key ways.

First, the BLI aligns with relationship-based care and is not defined by setting or geography. It can guide engagement with vulnerable First Nation adults living both in their home communities and away from them.

Second the updated BLI more strongly emphasizes a *Two-Eyed Seeing* approach¹. By bringing together Indigenous knowledge, values, and models of health and healing with Western knowledge and health systems, we aim to support care that is safer, more respectful, equitable, and collaborative—ultimately strengthening care experiences and outcomes.

Third, the BLI's value extends well beyond Adult Guardianship contexts. Many partners have shared that its principles are useful across a wide range of service environments, including policing, child protection, community-based work, and broader cross-cultural engagement.

Introduction and Context

The Adult Guardianship Act (AGA) in British Columbia provides the legal framework for supporting and protecting adults who are experiencing abuse, neglect, and self-neglect and who are unable to seek support and assistance independently. The BLI was developed in response to the deeper complexities of this work within Indigenous communities and with vulnerable Indigenous adults. The ongoing harms of colonization, including the legacy of Residential Schools, Indian Day Schools, the Sixties Scoop and Indian Hospitals – continue to shape the lived experiences of individuals, families and communities. Racism, discrimination, and loss of cultural connection have affected people in diverse ways, influencing how they understand their identity, purpose, home and belonging. In reflecting on these realities, important questions arose about what ‘least intrusive’ meant in this context, and how a ‘least intrusive’ approach should look when engaging with vulnerable Indigenous adults experiencing abuse, neglect, or self-neglect.

Since 2011, awareness and knowledge about the persistent impacts of Canada’s colonial history on the lived experience of Indigenous, Inuit, and Metis peoples have grown significantly. This increased awareness has been shaped in large part by the release of the **United Nations Declaration on the Rights of Indigenous Peoples** (UNDRIP)² in 2007 and the final report on **Truth and Reconciliation Commission of Canada**³(TRC) in 2015. In BC, the **In Plain Sight**⁴ report (2020) further exposed the depth and pervasiveness of Indigenous-specific racism and discrimination within the provincial health-care system. Since then, FNHA has provided strong leadership, working in partnership with provincial health authorities and service organizations to ensure Indigenous-specific racism in healthcare is identified, addressed and eliminated. These efforts have emphasized embedding

cultural safety and humility into policy, practice, and engagement frameworks. In revising the original version, our goal is to ensure that the BLI continues to serve as a leading evidence-informed tool that supports culturally safe and respectful engagement with vulnerable Indigenous adults. Just as importantly, we hope this update reflects our ongoing commitment to fostering care environments and encounters that are free from racism and discrimination, where Indigenous individuals and families feel safe when accessing support.

Being Least Intrusive blends Indigenous ways of knowing with critical social work principles. It is grounded in trauma informed practice, anti-oppressive theory, strengths-based and relational care. It supports an orientation to engagement and response that is **culturally safe**⁵ and:

- **Respects** cultural and spiritual diversity.
- **Supports** a wholistic understanding of health and wellness.
- **Creates space** for collaboration and partnership.
- **Recognizes** the strengths and resiliency of individuals, families and communities; and
- **Ensures** safety, protects dignity and encourages empowerment.

Being Least Intrusive represents a distinct approach to wellness and safety, challenging front-line workers to:

- Show up with intention, respect and care when working alongside individuals, families and communities.
- Views issues of vulnerability, abuse and neglect within the historical, social and cultural realities that shape people's experiences.
- Deepen self-awareness and understanding of how identity and experiences influence relationships and actions.

Foundational Principles and Concepts

The principles and concepts outlined below underpin the Being Least Intrusive (BLI) tool. Addressing situations of abuse and among vulnerable adults is a multi-faceted responsibility, and within the context of vulnerable First Nation adults, additional layers of complexity arise. A thorough understanding of these principles is vital in helping front-line workers develop a practice approach that mitigates risk, enhances safety and safeguards the dignity of those they serve.

Least Intrusive Most Effective

BC Adult Guardianship Legislation⁶ incorporates guiding principles intended to support front-line workers to intervene, support, and protect vulnerable adults with equally important ethical responsibility to uphold an adult's right to self-determination. Two critical principles are:

- Until the contrary is demonstrated, adults are **presumed capable** of making their own personal, health and financial decisions; and retain the right to decide how, where and with whom they want to live—even when those choices may involve risk.
- Adults must be provided with the **most effective and least intrusive** form of support, assistance and protection when they are unable to care for themselves, or manage their financial or personal affairs.

Anti-Oppressive Practice

Anti-oppressive practice is grounded in the critical social work tradition and is informed by a commitment to social justice. It focuses on identifying and understanding intersecting systems of oppression, privilege, and power operating at the structural level and shaping experiences at the individual and community levels. The approach seeks to challenge, disrupt, and dismantle dominant ideologies, discriminatory practices, and structural barriers. Rather than a specific method, anti-oppressive practice represents a stance toward practice, incorporating key concepts such as critical consciousness and reflective practice, the interrogation of power relations, solidarity with those marginalized by oppressive systems, and an emphasis on partnership and empowerment.

Trauma and Violence-Informed Care

Trauma and violence-informed care (TVIC) is a strength-based framework that recognizes trauma as both an individual experience and a response shaped by broader social and structural contexts. It acknowledges the significant short- and long-term impacts of trauma on health and well-being, including intergenerational effects. Trauma and violence-informed care emphasize safety, trustworthiness, choice, collaboration, and empowerment, while seeking to avoid re-traumatization and support individual and collective resilience.

Cultural Safety & Humility

Cultural Safety was developed by Irihapeti Ramsden, a Māori Nurse in New Zealand, as an educational framework for nursing practice⁷. It focussed on addressing cultural insensitivity, power imbalances and health disparities experienced by the Māori people. Ramsden defined cultural safety as an outcome defined by the recipient of care based on whether their cultural identity, values, and preferences have been acknowledged, respected and meaningfully considered.

In BC, the First Nations Health Authority (FNHA) emphasizes that cultural safety and cultural humility provide a protocol for health-care professionals, the FNHA, and health organizations to follow in their partnerships and relationships with First Nations. These concepts form the foundation for building relationships that are respectful, reciprocal, and create safe and meaningful ways to engage. FNHA defines these concepts as follows:

Cultural safety is an **outcome** based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care. Cultural safety is achieved when the voice of the people receiving services tells us they feel safe, seen, and respected.

Cultural humility is a process of self-reflection to understand personal and systemic biases, which supports the development of respectful relationships grounded in mutual trust. It involves acknowledging oneself as a learner when it comes to understanding another's experience.

Vulnerability and Capability

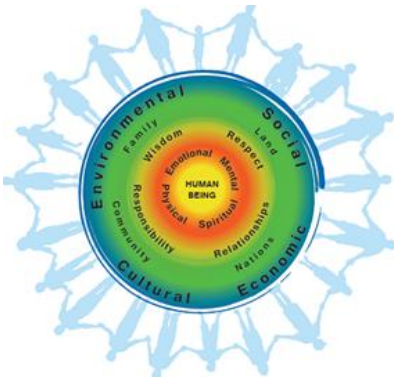
Issues of vulnerability and capability⁹ lie at the core of adult abuse and neglect investigations and are central considerations in adult guardianship and substitute decision-making legislation. These are complex individual and interconnected concepts:

- **Vulnerability is a social condition** that arises from and is shaped by intersecting factors such as poverty, isolation, ageism, physical and mental health, education, disability, gender and culture.
- **Capability** refers to a person's ability to carry out specific tasks or make decisions in particular categories. An adult may be capable in some areas while experiencing diminished capacity in others.
- Both **vulnerability** and **capability** are dynamic; they can shift over time and fluctuate with changing circumstances.

Attending to an adult's social environment, and to the factors that contribute to their vulnerability, is essential for understanding their capability in context and for ensuring responses are most effective and least intrusive.

First Nations Perspective on Health and Wellness

First Nations perspective on health^{10,11} is a wholistic vision of wellness, often expressed as circular, where all aspects of well-being including, physical, mental, emotional, and spiritual dimensions, are interconnected. It is strengths-based and a collaborative approach to health and healthcare that is grounded in First Nations' ways of knowing and wellness across the lifespan and generations¹². It differs significantly from the definition of health in mainstream healthcare.



In FNHA's visual depiction of First Nation's Health perspective, **good health** starts with every human being and then extends outward to include broader social, economic, cultural and environmental determinants of health and wellness.

- **Centre circle:** Wellness starts with individual human beings taking responsibility for their own health and wellness
- **2nd circle:** Balancing and nurturing one's Mental, Emotional, Spiritual and Physical well-being is fundamental to whole health and wellness.
- **3rd circle:** The overarching values of respect, wisdom, responsibility and relationships support and uphold wellness.
- **4th circle:** Depicts the people around us and the places from which we come. They are all critical components of our health experience as human beings.
- **5th circle:** Social, environmental, cultural, and economic determinants also impact and influence health and well-being.

Meaning Centered Practice

Meaning Centered practice¹³ is a framework that attends to the spiritual, cultural, worldview and meaning systems that people use to interpret their experience and make sense of their world. It is focused on the co-creation of shared understanding and meaning through recognizing and weaving together multiple ways of knowing and building capacity to navigate complexity, tolerate ambiguity and engage with curiosity. Key aspects of this approach include:

Humble Reflexive Inquiry: clinicians engage as a ‘humble learners’, centering the client’s knowledge, perspective and their interpretation of experience as a starting point for curious, open inquiry. This is coupled with the practitioner’s commitment to interrogating the way in which their own view of the world is socially and culturally located and shapes knowledge, awareness, interactions and understanding.

Collaboration: engagement is a two-way exchange in which meanings and understandings are shared, explored, and collaboratively co-created through a dynamic, generous and iterative conversational process.

Respectful: engagement honours diverse ways of knowing and being; centers the client’s voice, wisdom and experience; and explores the multiple and intersecting meanings embedded in stories of lived experiences.



Being Least Intrusive: The Tool

Being Least Intrusive (BLI) is a practical tool designed to guide front-line workers through a process of critical preparation, assessment and reflection. It is organized into three sections and uses guided questions to build self-awareness, support a more wholistic assessment and promote culturally safe engagement with clients, families and communities.

Orientation to SELF

When: Before engagement

Action: Develop a critical self awareness: attitudes, values, assumptions, social location and power dynamics.

Orientation to CONTEXT

When: Before engagement

Action: Ground approach in culture and community; gather case information within the context of a wholistic assessment.

Orientation to REFLECTION

When: After engagement

Action: Debrief case; seek feedback on the engagement process and identify improvements to strengthen practice.

Orientation to SELF

When: Before engagement

1. Clarify who I am in this work (my personal and professional role, social location, cultural affiliations, worldview, etc.). *Q. How do my social location and lived experiences shape what I notice, assume, and prioritize – where might that create blind spots and power imbalances?*
2. Examine my attitudes and assumptions about abuse and neglect of vulnerable adults, including vulnerable First Nations adults?
Q. What am I assuming is ‘abuse/neglect’ here and who defines that? What biases might be influencing how I understand the situation?
3. Identify any values or biases that could impede my responsibility to create a safe environment and a safe encounter for the individual and/or family. *Q. What values of mine are being activated here and how could they be narrowing my understanding, response, and responsibility to create safety for others?*
4. Reflect on who I am in relationship to the individual, family, community. *Q. How might I be experienced in this moment (helper, outsider, authority, system rep. and how could that shape safety and trust?*

Orientation to CONTEXT

Community & Culture

When: Before engagement

1. Identify community resources available, including social and health care services.
2. Learn and incorporate any relevant community protocols.
3. Partner with the most appropriate people in community, those with knowledge of and connection to individual and/or family, who are trusted, who can act as cultural guides, and can support the development of a culturally safe and appropriate plan for support and assistance.
4. Review your organization's history of engagement and collaboration with the community related to service delivery.

Orientation to CONTEXT

Case Specific

When: Prior to engagement with client/family/community

1. Observe, identify, and document the objective details of the situation (the facts, the specific concern reported, and who is involved?)
2. Confirm who reported the concerns of abuse and neglect (e.g. client, family, community member, or service provider) and their connection to the situation.
3. Assess whether your involvement with the client/family/community is likely to be welcomed. If not welcomed, consider how a relationship of trust and safety can be developed.
4. Engage others only as needed and share information in ways that respect confidentiality and privacy and uphold the dignity of the client and family.

Orientation to CONTEXT

Gathering Information

When: Over the course of multiple interactions with the client and involved family, caregivers, and service providers

1. Explore the client experience of agency and ability to take responsibility for their own health and wellness, including balancing, nurturing, and strengthening the physical, mental, emotional and spiritual aspects of their own health well-being?
 - *What are the words they use to describe their current state of well-being and functioning across these dimensions?*
 - *How do they make sense of the current situation?*
 - *Do they have any specific concerns about any aspects of their health and well-being?*
 - *How do the client's perspective, experience, and meanings differ from those of their family, caregivers, and service providers?*
2. What is the client's experience of connection and belonging to:
 - *Family: Who is important to them, what is their role within the family?*
 - *Community: What is important, what is their role within their community?*
 - *Culture: what are their traditions, values, and spiritual practices?*

Orientation to CONTEXT

Assessment

When: After as much relevant information as possible is gathered

1. Identify client strengths and sources of vulnerability across wholistic dimensions based on the context of the client's lived experience.
 - **Physical:** *Physical functioning, health status, activity.*
 - **Mental:** *Cognitive functioning, mental health, learning and education.*
 - **Emotional:** *Self-esteem, sense of agency over factors that affect everyday life, livelihood, and health.*
 - **Spiritual:** *Cultural identity, spiritual practices, integration of past and present.*
 - **Relationships:** *Connection and belonging to family, extended family, community, land, creation)*
 - **Social:** *Income, food and housing security, language, access to support and resources*
2. Clarify your understanding of health and well-being and how it might differ from those of the client, family and community.
3. Identify ways you can distinguish your values regarding standards of care, family relationships, and physical surroundings from those of the client, family, and community.

Orientation to REFLECTION

When: After intervention; happens over time

1. *Was I “least intrusive and most effective” in the intervention? Did I respect the client’s autonomy and self-determination while also balancing the need for support and assistance?*
2. *Did the client experience my involvement as culturally safe and how do you know? (Did you take the client’s cultural identity, values, and preferences into account? Did you engage the client meaningfully? Did they help develop a respectful, appropriate plan? Did the client welcome your involvement? Were you invited back?).*
3. *What did you learn about yourself? (Were your values, assumptions or interpretation of the situation, client, or culture challenged?)*
4. *What feedback did you receive from the client, family, community, colleagues about the engagement and overall process?*
5. *How can you improve your practice next time?*

Using the BLI Beyond Original Scope

Through consultation and feedback, we have learned that many frontline service providers, community agencies, and service organizations see value and opportunity in using the BLI tool beyond its original scope. They recognize that the BLIs guiding principles support positive human relationships generally, and more specifically foster culturally safe, respectful, and meaningful engagement.

The BLI tool can be used across care and services settings, across culture and differences, and beyond case specific interventions. Each section of the tool invites reflection and thoughtful engagement with self, with the individuals, families and communities with whom you work and within the context of lived experience. Fundamentally this orientation starts with you. Each of us has a role and responsibility to contribute to the health and wellbeing of ourselves and others, and the safety of the systems within which we work.

Being an effective helper begins with caring for your own well-being; mind, body, spirit, and emotions. Prioritize self-care and self-awareness before, during, and after your time in community spaces. When you are grounded, you are better prepared to listen, understand, and offer support with clarity, confidence, and presence.

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BLI 2011 is one in a series of tools in the National Initiative for the Care of the Elderly (NICE) Tool Kit designed to detect, intervene in, and/or prevent abuse of seniors. For more information about this, or any of the other Tools and related training events, please visit www.nicenet.ca.

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