

OCCUPATIONAL THERAPY NOW

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Commission

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Angie Phenix



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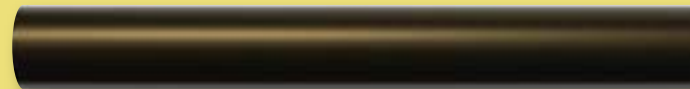
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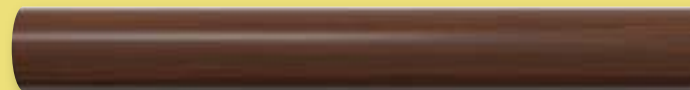
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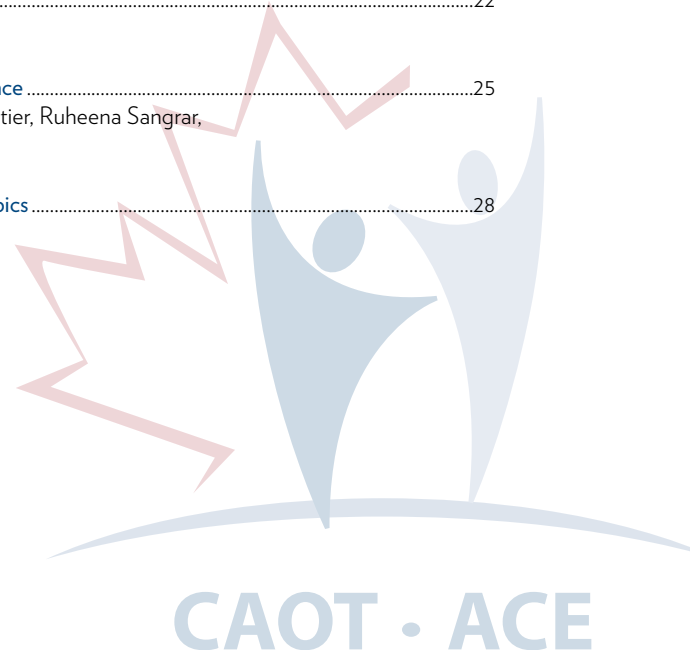
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Occupational therapy responses to the Truth and Reconciliation Commission

Angie Phenix and Kaarina Valavaara

Taanishi

“We have to start from the inside out.”

Our names are Angie Phenix and Kaarina Valavaara. We are two Métis women, occupational therapists, and current co-chairs of the Occupational Therapy and Aboriginal Health Network. We have been advocating, alongside our network’s members and allies in the Canadian Association of Occupational Therapists and broader occupational therapy community, for increased awareness of occupational therapy’s role in addressing the ongoing health and education inequities, racism, and oppression experienced by Indigenous Peoples. We also continue to advocate for how occupational therapists can turn this awareness into action through fulfilling the calls to action of the Truth and Reconciliation Commission of Canada (TRC; 2015).

The TRC’s work involved five years of Indigenous and non-Indigenous community consultations, hearing stories about Indian Residential School experiences and their effects. The TRC’s final report detailed this dark piece of Canadian history and set out 94 concrete “calls to action” for all Canadians to collaboratively repair the harm done and build mutually respectful relationships between non-Indigenous and Indigenous Canadians—so that these atrocities cannot happen again. As expressed by chair of the TRC, Honourable Justice Murray Sinclair, in remarks about the process of reconciliation in an interview for the *Ottawa Citizen*: “This is a Canadian problem. Because at the same time that aboriginal [sic] people were being demeaned in the schools and their culture and language were being taken away from them and they were being told that they were inferior, they were pagans, that they were heathens and savages and that they were unworthy of being respected—that very same message was being given to the non-aboriginal children in the public schools as well” (Kennedy, 2015).

The calls to action of the TRC specifically provide health care practitioners, including occupational therapists, with concrete guidance for how to redress the legacy of residential schools and promote equitable health outcomes for Indigenous and non-Indigenous people in Canada. Crucial in this process is a need to confront hard truths about our personal and professional positions within Canadian society, and our own biases and experiences, in order to build new mutually respectful relationships between Indigenous and non-Indigenous people in Canada. As occupational therapists, for

example, we argue for a shift away from occupational therapy models and theories that do not typically include analysis of ourselves as the therapist and indeed set the client as an “other.” We believe it is critical that we centre and examine the therapist, with all of their beliefs, history, bias and positions, if we are to truly be in mutually respectful relationships with Indigenous Peoples (Valavaara, Phenix, & Restall, 2017). This work of confronting, learning, reflecting, and acting is difficult, as it challenges us to examine our core beliefs, roles and histories—both professionally and personally—and requires courage to envision a new way of undertaking occupational therapy relationships and practice. It encourages us to look beyond the individual client and examine how occupational therapists can address the societal power imbalances between Indigenous and non-Indigenous people in Canada by respecting and facilitating Indigenous Peoples’ rights to occupational engagement and participation (Hammel, 2016).

We have found ourselves expressing this idea with the phrase “starting from the inside out,” which has kept crossing our lips in our conversations with each other throughout the process of guest editing this special issue and has guided us in selecting which articles to share. This phrase has also reinforced how deeply personal this process of reconciliation and decolonization is to us as Métis women. As Indigenous scholar Margaret Kovach beautifully summarized, “we can only go so far before we see a face—our Elder cleaning fish, our sister living on the edge in East Vancouver...—and hear a voice whispering, ‘Are you helping us?’” (Kovach, 2005, p. 31).



Angie Phenix and Kaarina Valavaara, guest editors.

We are honoured to have the opportunity to highlight in this special edition the stories of the reconciliation journeys of occupational therapists across the country. We are humbled by people who shared stories of their own vulnerability and tell of learning, unlearning, and action, and we thank these authors for their honesty. There is not a single or easy way to change and advocate for our practice(s) to be more culturally safe and anti-oppressive—but it is our hope that these stories can serve as inspiration and assurance that we all enter into this journey at different times and places and can take action at many different levels within occupational therapy. As you read through this collection of stories, we ask you to be curious and open to considering how you too can take action to respond to the calls to action of the TRC.

Marsee (Thank you)

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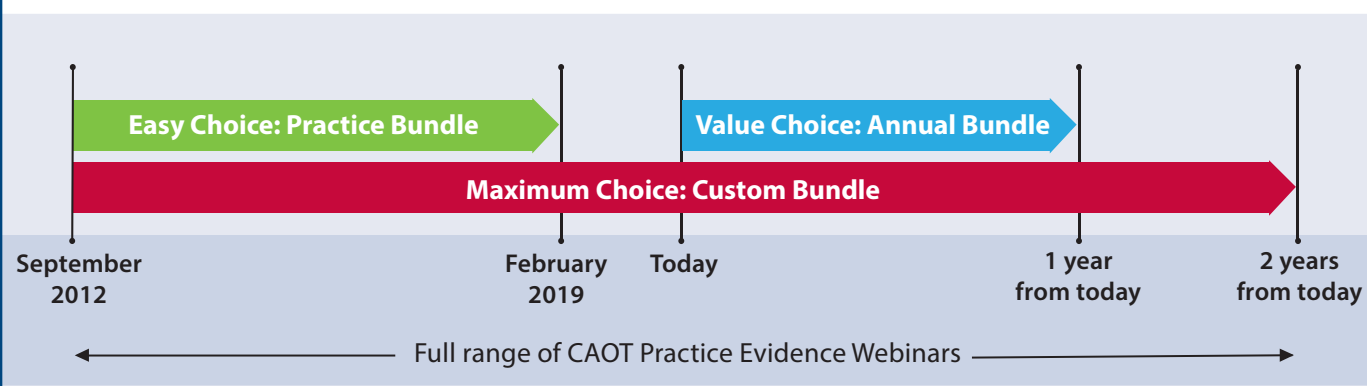

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A Four-Year PhD journey: Two-eyed seeing in Community Action Research

Justine Jecker

Four years ago, a community action research partnership developed between researchers from Lakehead University, myself—Justine Jecker—and six First Nation communities affiliated with Nookiiwin Tribal Council. My relationship with these communities was formed through a shared understanding that the Truth and Reconciliation Commission’s calls to action (2015) provided a decolonizing action-oriented pathway for non-Indigenous persons seeking change with Indigenous Peoples. The specific calls that we chose to guide our research included acknowledging that previous health policy is responsible for current understandings of Indigenous health (#18), the need to identify appropriate health services (#19), the need to recognize the value of traditional health practices (#22), and the need to provide competency training for health professionals (#23) (TRC, 2015).

To implement these calls, the “two-eyed seeing” approach was used to represent the views of Indigenous and non-Indigenous participants (Bartlett, Marshall, & Marshall, 2012; Martin, 2012). Mi’kmaq Elders Albert and Murdena Marshall introduced this model to build capacity within Indigenous communities, reflective of true partnerships in health research and knowledge exchange (CIHR, 2014). Two-eyed seeing is unique as it allows for multiple perspectives that can be used to decolonize knowledge through the process of “co-learning” (Bartlett, Marshall, & Marshall, 2012). This approach encourages inter-cultural collaboration, as Indigenous Knowledges are represented as one eye, and Western knowledges are represented as the other eye. When used together, binocular vision represents components of both worldviews (Marshall, 2017).

With the calls to action and two-eyed seeing approach to guide our direction, the research process began in 2015. During the first two years, our research team worked intimately with Nookiiwin to ensure that research could be done “in a good way,” supportive of the Anishinaabe concept of G’minoomaadozimim (“We Are Living Well”). Doing research “in a good way” meant engaging in pre-search activities that would enable us to establish a clear research purpose and supporting questions. This time was referred to as “Seeing the vision” and “Realizing the vision,” as is seen in Figure 1. We dedicated ourselves to building relationships with community members, completing a needs assessment that examined local understandings of health and wellness, and identifying available services in the region through the process of web-mapping. By the end of second year, we identified the purpose of the research: to improve access to culturally

appropriate services through interprofessional collaboration training. Our third year, “Figuring out the vision,” commenced with communities engaging in a one-day interprofessional collaboration workshop, focusing on the competencies of role clarification, interprofessional communication, conflict resolution, team functioning, collaborative leadership, and community-centred care (Orchard et al., 2010). These experiences led to: 1) the development of a culturally appropriate Community Resource Guide (www.nookiiwin.com/crg), 2) the translation of research results into Ojibwe, 3) the Community Action Research Framework (Figure 1), and 4) the portrait, *A Gathering of Wellness*, by Kevin Belmore (Figure 2).



Figure 2: Kevin Belmore, *A Gathering of Wellness*.

Figure 1 depicts my PhD journey. I am represented in a canoe at four different points along a river radiating the colours of the medicine wheel. Bell’s (2014) concept of growth inspired my transformation: from infancy, to childhood, to adulthood, and to wisdom. In alignment with Nookiiwin Tribal Council’s understanding of the medicine wheel, the yellow path represents spiritual connections with communities, the red path represents emotional wellness and strength needed to engage in research, the black path represents the physical wellness needed to engage in data collection and analysis, and the white represents the mental wellness needed to translate

findings to fellow knowledge seekers. The four seasons of each year are represented by a leaf for fall, snowflake for winter, flower for spring, and sun for summer.

To capture the community understanding of the research, the process of portraiture (Lawrence-Lightfoot & Davis, 1997) was used by artist Kevin Belmore. The portrait, entitled *A Gathering of Wellness*, represents the ongoing journey to achieving holistic community wellness—inclusive of spiritual, emotional, physical, and mental wellness (Figure 2). The canoe is coming from the east gathering knowledge, medicines, and wisdom, representing the partnerships established throughout the journey. The medicine wheel represents the story-telling and knowledge gathering that took place, which allowed participants to uncover knowledge and wisdom that represents the region. Representation of the four generations and animals denote a return to cultural ways and values. Lastly, the eagle watches over us, Indigenous and non-Indigenous beings, supporting the two-eyed seeing lens that enabled us to address calls to action while focusing on improving access to culturally appropriate services for communities.

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Figure 1: Community Action Research Framework 2015–2019.

About the author

Dr. Justine Jecker, OT Reg. (Ont.), relocated to Thunder Bay, ON, after completing her MSc. Occupational Therapy degree at McMaster University in 2009, and began working in the fields of forensic and community mental health. As a novice provider, she began to learn about Indigenous Peoples for the first time; now, ten years later, she offers her experiences to practitioners in pursuit of truth and reconciliation with those who were first to call these lands home. She has completed her PhD at Lakehead University and can be reached at: jjecker@lakeheadu.ca.

Five things I learned from working with Indigenous Peoples in Canada

Michelle Viengkone

As a second-year student occupational therapist, I am also a participant in the University of Alberta Occupational Therapy program's Indigenous Focus. This initiative aims to increase student awareness of issues facing Indigenous Peoples and to prepare us to provide culturally safe care to our future clients, through providing additional coursework, meetings, and fieldwork opportunities. Additionally, prior to entering occupational therapy, I worked with Inuit and Dene people in the Arctic and Subarctic as a biologist, and with Treaty 7 communities in Alberta doing educational outreach. These experiences have shaped my understanding of how to partner with Indigenous communities.

I realize that my lived experiences have provided me with insights that may help other non-Indigenous students and practitioners who may want to partner with Indigenous Peoples but do not know where to start. I have shared these insights as five lessons that I have learned over my time partnering with Indigenous communities. My aim is to help others in their journeys to build “mutually respectful relationships” as set out in the Truth and Reconciliation Commission of Canada's calls to action (TRC, 2015a).

Lesson 1: Understand yourself and realize what you do not know

When I started working in Indigenous communities, I found it helpful to reflect on my own identity first. It takes practice and patience to examine one's self; it is equal parts critical reflection and empathy. Through reflection, I recognized how aspects of my story are similar to and different from some of the experiences of Indigenous Peoples, which has helped me to empathize with individuals over commonalities and to better recognize the gaps in my knowledge. Taking responsibility for one's own learning is necessary for knowledge development and is an act of putting truth first.

For many non-Indigenous Canadians, Indigenous Peoples' experiences are not known or well understood. The Report of the Truth and Reconciliation Commission of Canada (2015b) can be a place to start, as it highlights the discrepancy in understanding of Indigenous history and life among Canadians, and it brings forth calls for action and change. After reading the calls to action, I made a commitment to address my areas of ignorance by listening to and reading from Indigenous authors, artists, and media.

Lesson 2: “Just like snowflakes, no two people are alike” – Casey Eagle Speaker

We each have our own story to share. This teaching has remained with me since my very first encounter with Casey Eagle Speaker (2015), an Elder from the Kainai Nation. Acknowledging others as unique individuals allows you to get to know them for who they really are. It requires non-Indigenous people to challenge stereotypes and the narratives we held about Indigenous Peoples. To really learn from and listen to Indigenous Peoples requires an understanding of colonialism, particularly an awareness of intergenerational trauma and its manifestations in phenomena such as addiction and abuse. Indigenous Peoples' stories of lived experience may not focus on or involve trauma; however, it is important to be informed of the historical and ongoing impacts of colonization.

This teaching also applies to communities. Each community has its own quirks, strengths, challenges, and traditions. Taking time to appreciate the diversity of cultural groups is important in acknowledging the different needs and interests of each community. A good way for non-Indigenous people to understand Indigenous people and culture is to engage in events like powwows, fishing derbies, or medicine walks. Getting to know one person or many involves patience and investing quality time.

Lesson 3: We are better together, stronger side-by-side

During the TRC community gatherings, Indigenous Elders met on the land of the *xʷməθkʷəy̓əm* (Musqueam) people in Vancouver, BC, and released a statement that captures the importance of working together and finding common ground: “Our traditional teachings speak to acts such as holding one another up, walking together, balance, healing and unity. Our stories show how these teachings can heal their pain and restore dignity” (Truth and Reconciliation Commission of Canada, 2015c, p. 218). In my personal journey I have found several ways to honour these words:

Engage with others in respectful dialogue: In my program's Indigenous Focus, we have created a safe space to voice our opinions and learn from one another and from guest speakers. We recognize the importance of walking alongside one another as we push ourselves and each other to challenge our professional and personal worldviews. For example, we have discussed how we can be more culturally safe in our

assessment tools and processes, which has empowered us, in a way that we could not do on our own, to challenge the status quo when we enter practice.

Embracing other ways of knowing: In my experience as a biologist, I collaborated with Inuit hunters to collect polar bear DNA to bring awareness to the value of Traditional Knowledge in tracking bears, in addition to the commonly accepted scientific knowledge. Both scientific knowledge and Traditional Knowledge have their strengths and can contribute to a better understanding of the world. This challenged me to think how, as a future occupational therapist, I can respect Indigenous ways of knowing and strive to collaborate rather than force our clients into the Western worldview from which many occupational therapy theories and models are derived.

Lesson 4: Make the most of mistakes

From my early days of working alongside communities in Treaty 7, I learned from mentors that I would inevitably make mistakes. From miscalculations to misinterpretations of protocols, conversations, and expectations, mistakes happen and are a part of the learning process. I recall one mistake where I asked an Indigenous colleague to speak at an event, sharing her personal knowledge and experiences. Although my intentions were good, I did not realize that I was asking her to represent herself as a Knowledge Keeper, which she did not feel comfortable representing herself as. I had not done my homework to find an appropriate Knowledge Keeper, and had put an Indigenous colleague in an uncomfortable position. I knew that I needed to do more learning to not make the same mistake again.

We do not always say or do the 'right' thing, but by humbly admitting and correcting our mistakes, and setting the intention to do better next time, non-Indigenous people and practitioners can continue connecting with Indigenous Peoples and communities.

Lesson 5: Honor the ties

The relationships and bonds that non-Indigenous health care practitioners co-create with an Indigenous person or community are important to maintain and protect—I cannot emphasize this enough! In the beginning, like any new friendship, it can be difficult to connect. There is good reason for mistrust with the current and historical mistreatment of Indigenous Peoples and cultures. Recognizing this can help non-Indigenous practitioners to be respectful, compassionate, and understanding that relationships will take time to cultivate.

Relationships are about communication, active engagement, and building trust where there was none. I have found that

as relationships develop, they are key moments that can either make or break this trust. I once had an external sponsor demand the product of collaboration with an Indigenous community without their consultation. This made me uneasy: the product was not mine to give without permission and doing so would jeopardize my relationship with the community. I held my ground and refused to provide our work without consulting the community. It is a choice I stand by, despite the friction it caused: by putting the relationship first, I was choosing to break the cycle of mistrust and mistreatment: I instead chose to facilitate positive and compassionate interactions that move us all towards equity.

I hope my lessons have provided some guidance and re-assurance of the journey to building mutually respectful partnerships with Indigenous Peoples. Though I have learned much about myself, our country, and Indigenous Peoples, there is still much to understand, and do. Through the act of listening and supporting others as they develop their voice, we can connect: human to curious human. We are all Treaty people, and by drawing on truth and committing to reconciliation, we can move forward together towards harmony.

Acknowledgements:

Thank you to all the Indigenous persons who have shared their stories of resilience and wisdom with me. What I know is a product of these invaluable interactions. Thank you to my parents, and partner, Marcus Cunningham for challenging me in my thinking and learning. Special thanks are due to Kaarina Valavaara and Susan Mulholland for feedback during this process.

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Michelle Viengkone, MSc, is second-generation Asian Canadian woman living in Calgary where she is currently completing her Master of Science in Occupational Therapy at the University of Alberta. For questions please email: viengkon@ualberta.ca.



Navigating occupational therapy's role in redressing inequities with Indigenous Peoples: Walking the talk as a new graduate

Ally Forrest

I identify as a middle-class woman who has been privileged with many opportunities, including my education. Though my father's side of my family identifies as Métis, my German-Mennonite upbringing had never exposed me to the injustices that Indigenous Peoples in Canada face. I have a Métis Citizenship card, but what does that mean? I had never previously felt that I could truly take ownership of that part of me, because I knew nothing about the culture or what it means to be a Métis woman. After entering the occupational therapy program at the University of Manitoba, my curiosity and desire to understand more about my family's history and the history of Indigenous Peoples in Canada started to grow and influenced many of my decisions as a budding professional. This article is a reflection on my time as a student and new graduate and on how I have begun to apply what I have learned to my practice.

During my first year of the Master of Occupational Therapy (MOT) program, I had the opportunity to participate in a pilot project through the Office of Interprofessional Collaboration, which placed me in Fisher River Cree Nation, Manitoba. I was excited, nervous, and honoured. For two weeks, I worked with an interprofessional student team to learn with, and from, health centre staff and community members about life and health care in a First Nations community. My time there was overwhelmingly positive; the community members welcomed us warmly, invited us into their homes, and shared their cultural practices. After hearing about their stories of resilience, their needs, and the barriers they faced, I knew that I needed a deeper understanding of how occupational therapists can work with communities like Fisher River to improve health care and engage in reconciliation.

During my second year, my group research project aimed to explore the current state of knowledge in Western countries with similar histories of colonization about the integration of Indigenous culture, practice, and research in occupational therapy. The group's efforts resulted in a scoping review summarizing how occupational therapists have begun to redress the harms caused by colonialism and work toward improved care with Indigenous Peoples. We identified seven themes across the 74 articles reviewed that have implications for occupational therapy practice: considering contexts, reflection, ways of knowing, the role of occupation, education, research, and partnerships. Overall, we concluded that occupational therapy as a profession has begun to make efforts to integrate Indigenous culture and contexts with

practice in countries with a history of colonization, but there is much work yet to be done in terms of eliminating inequities that Indigenous clients experience in health care worldwide (Forrest, Hogg, Snure, & Wilkie, 2018). This project offered the opportunity to learn from our knowledgeable advisor, Gayle Restall, and to meet with Margaret Lavallee, the university's Elder-in-residence, and Kimberly Hart, the senior lead of Indigenous Health Student Affairs, who graciously gave feedback on our word choice, use of language, and assumptions, as well as shared their own stories of trauma and resilience. Through participating in this research project, I truly began to recognize the many health care inequities that exist for Indigenous Peoples and the minimal, though growing, knowledge of these injustices within the occupational therapy profession. At this point in my education, I had built a foundation of literature and personal experience to guide me regarding how to begin effecting change in the health care system as an occupational therapist.

After graduation, my interest in rural and northern communities and my growing passion for improving the health care experiences of Indigenous Peoples led me to accept a position in a remote community over 600 kilometres north of Winnipeg, Manitoba, as a mental wellness occupational therapist. As I would be working with the psychiatric acute care unit, the community mental health team, and the addictions centre, with a client population that is predominantly Indigenous and a variety of ages, I knew this would be the ultimate opportunity to put into practice what I had learned through the scoping review—it was time to “walk the talk.” As the position had been vacant for three years prior to my arrival, I had a significant amount of work ahead of me: I had to define my role as an occupational therapist in mental health in the north, try to consistently incorporate the cultural learning I had done over the past two years, and ensure I was engaging in evidence-based practice, all while trying to remember the theories and acronyms the MOT program had thrown at me—new grad, new job, new town, new culture.

For the short time I have been in my position, I have been striving to stay true to the lessons learned from our scoping review: I remind myself of the impacts of colonization and the resulting power imbalances between Indigenous Peoples and their health care providers; I invite family members into therapy sessions as appropriate; I utilize conversation rather than direct questioning or standardized assessments as much as possible; I take time at the end of the week to reflect on

how my clients' and my values and backgrounds may have influenced our interactions; and I work with my clients as partners. I am also still learning how to effectively describe to Indigenous clients what occupational therapy, a profession based in Western ideologies, can offer them in their mental wellness journey—a task that has proven challenging, as I am still learning what this role can include.

One recurring challenge throughout my clinical experiences in diverse practice settings has been working with colleagues whose ranges of perspectives, assumptions, and biases have prevented a given team from providing consistently effective and culturally safe health care to Indigenous clients. I have heard comments like: “He’s a frequent flyer here, we’ll adjust his meds and send him back to his community,” “His mom just needed some respite; we’ll discharge him home in a couple of days,” and “You want to get her splints for her rheumatoid arthritis? All she does is drink, so she’ll be dead in six months anyway.” If our clients have repeat readmissions, why are we not exploring what is not working? If our clients have goals to improve the quality of their lives, why are we not doing everything we can to work with them and their families to achieve those goals? How can we, as health care teams, implement changes in the remote Indigenous communities from which many of our clients come?

I recognize that I still have much to learn about the realities of the north, and there are many stories I have yet to hear. I do not claim to know much, but I do know I am committed to making positive, lasting changes in my practice, and hopefully, with time, can influence the practice of many occupational therapists and other members of health care teams. I am still

figuring out what that might look like, but for now I am trying to incorporate my MOT learning into my practice and take time to reflect critically on how I apply my previous learning to my current day-to-day work. Through reflection, I find I learn something new every day. I have learned that being familiar with Canada’s history of colonization has given me a greater understanding of why some Indigenous clients are experiencing what they’re experiencing, which guides my conversations with them and helps me in working with them to plan for their futures. I have learned that taking the time to cultivate trusting relationships and ask questions about cultural values and practices makes the care I provide more relevant. I am learning to balance advocating for myself and my profession with recognizing when I may not be the best fit for someone on their recovery journey. And, I am still learning about my own family’s history and exploring what meaning that may add to my practice. My job in the north and working toward reconciliation will be by no means easy, but the most important things in life never are.

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Canadian Association of Occupational Therapists



Reflecting on Indigenous access to informed consent

Lisa Boivin and Janna MacLachlan

We, Lisa and Janna, have a shared interest in examining colonial processes in health care. This has led to many deep conversations in which we have shared personal experiences and learning. Lisa's experiences come from being a Dene woman who is a Sixties Scoop survivor from generations of residential school survivors, and Janna's experiences come from being a white woman of settler ancestry providing occupational therapy services in Inuit communities. One such conversation centred on the idea of informed consent and whether or not it is equally accessible to Indigenous Peoples in health care settings. In this article, we share some things we have learned by exploring this topic through story and reflection. As an image-based storyteller, Lisa will tell part of this story with images.

Generally, health care professionals envision the consent process to look something like this: Figure 1.

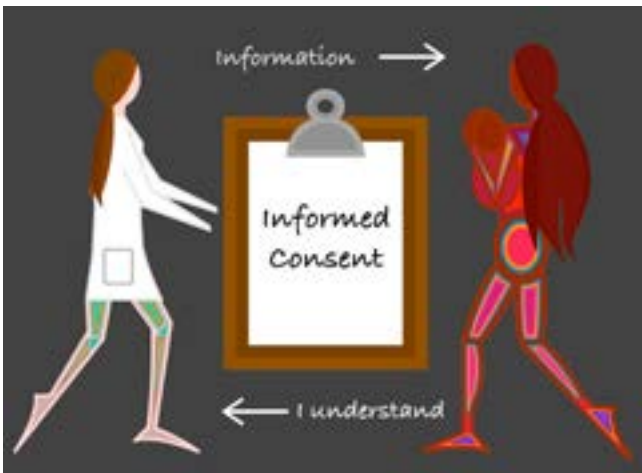


Figure 1
How clinicians understand informed consent. Patient and clinician are on an equal level and both have an opportunity to share desires and concerns.

However, we contend that many Indigenous people experience the consent process more like this: Figure 2.

Janna: *During my practice experience working in Indigenous communities, I recall many times that the consent process didn't quite feel right. I once visited a community and saw almost none of the children on my caseload attend scheduled appointments, but on a return visit almost everyone scheduled showed up. The only difference between the two trips was that the child protection social worker happened to also be in town during that second visit. Did the families come because they were afraid I would report them if they didn't? A parent once told me over the phone that it would be too difficult to get to the health centre for an appointment. I offered that instead I could visit their home to make it easier, and the parent's response was "I'll be there in 15 minutes." Had I just inadvertently threatened her?*



Figure 2
How many patients experience informed consent. The patient is overwhelmed with information and may not feel they have the power to refuse what has been recommended by the health professional.

Health and social services for Indigenous Peoples in Canada are marked by a long history of not seeking consent. Examples include parents of children in residential schools not being informed of interventions given and people being forcibly relocated to distant sanatoriums for tuberculosis treatment. It would be a mistake to believe that this issue resides exclusively in history. For example, the federal government requires First Nations to accept provincial or territorial child welfare laws in order to receive program funding, preventing the implementation of Indigenous laws or cultural approaches to supporting families to hold ground (Blackstock, 2015). This example points to an important part of the consent problem; it is still being sought on non-Indigenous terms. The "rulebooks" of how health is defined, what constitutes consent, and how it should be executed are all written from the perspective of a Western worldview (McGrath & Phillips, 2008). The imposition of these norms is in opposition to Indigenous rights to self-determination, as described, for example, in the United Nations Declaration of the Rights of Indigenous Peoples (United Nations, 2008).

Lisa: *The intergenerational loss of and/or threat of losing children is a reality for my family. I am a Sixties Scoop survivor from generations of residential school survivors. I am aware of the power that health care professionals possess. For example, the day after my daughter was born, a social worker came to visit me in the hospital. She asked me questions about my housing and my income and if I was prepared to look after my baby. During this conversation, my mother (who is white) arrived in my room and sternly told the social worker, "Get out!" The social worker left promptly and did not return. However, fear stayed with me. Every time I took my daughter*

to the doctor, I made sure she was freshly bathed and wearing spotless clothing. When she had to go to the public health nurse for immunizations, I took my mother with me. At the time, I was very young and didn't think critically about informed consent in clinical relationships. Looking back, my fear of losing my baby made me vulnerable. I can say with certainty that accessing informed consent would be very difficult in situations such as these.



Figure 3
The Medicalization.

Lisa: *The lingering effects of residential school prevented my father from fully engaging in conversations with clinicians. My father had polio as an infant, which left him with a mobility impairment. While he was at residential school, he had multiple surgeries and endured torturous rehabilitation treatment plans to regain his mobility. All of this took place without my grandparents' consent. At a very young age, my father was led to believe that he could not take care of himself because paternalistic clinicians medicalized his mobility and made decisions for him throughout his childhood. Consequently, any clinical conversations in his adulthood were met with skepticism and distrust.*

My father passed away before I began studying rehabilitation science. I didn't have the opportunity to ask him if he felt he had access to informed consent. From a clinical perspective, I would say, "No, informed consent cannot exist when one party does not trust the other." Considering my father's history, why would he trust a clinician? He was taken away from his family and medicalized in residential school. When he was an adult, I was taken from him because he was an Indigenous man with a diagnosed disability.

Janna: *I don't believe anyone becomes an occupational therapist intending to reproduce colonial forces or coerce people into conforming with Western health care expectations, but the more I listen to Indigenous voices, learn about Indigenous worldviews, and reflect on my practice, the more I recognize how much I am implicated in systems and practices that do just that. I discovered*

I didn't know how much I didn't know, and I still don't. I was so grounded in the Western worldview being the taken-for-granted norm that I had no idea how many assumptions I had been making or what other ways of knowing and being there might be.

Lisa: *Canada's colonial history creates a huge power imbalance between clinician and patient. Clinicians often don't understand this. When I have brought this up, I have heard different variations of the phrase "That was then and this is now." However, intergenerational trauma is powerful, and colonialism is ongoing. Clinicians must have a fundamental understanding of colonialism and how it impacts the health outcomes of Indigenous individuals and populations. Informed consent can only take place when both parties come together with a sense of balance and awareness of each other's position in the clinical relationship. It is worth mentioning that this is a time-consuming endeavour. Good and balanced relationships take time to form. A clinician cannot possibly eradicate the harm caused by centuries of failed relationships between colonial institutions and Indigenous people in one visit.*

I represent informed consent in the form of a clipboard in all of the images shared in this article. I understand informed consent as a sacred ceremony between patient and clinician. It is both parties coming together with the same goal, which is to allow the patient to determine their own clinical/health path. This should take place with full disclosure and without coercion.

As occupational therapy is largely informed by a Western worldview (Gerlach, 2012), we have to recognize when we might be missing things that are important from the perspectives of Indigenous worldviews. Do health care spaces, laden with colonial baggage, allow enough room for a balanced exchange in the informed consent process? Do they support Indigenous rights to self-determination? We know there are no easy fixes, but are hopeful that by building relationships, listening, unlearning assumed norms, and being reflexive, humble and open, we can begin to work toward restoring some balance in the informed consent process.

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Numbers, measures, and metrics: Part of our ongoing decolonization journey

Cary Brown, Michele Moon, Kaarina Valavaara, Cori Schmitz, Susan Mulholland, Karin Werther, and Shaniff Esmail (Department of Occupational Therapy, University of Alberta)

In response to the calls to action of the Truth and Reconciliation Commission of Canada (TRC; 2015) we embarked on a path to identify and address racism and colonialism in our curriculum through consultation with students, Indigenous knowledge keepers, and stakeholders. Call to Action 18 challenged us to design learning opportunities making direct links between historically abusive, traumatizing practices and current health conditions. Calls to Action 19 through 22 identified essential areas in which students can be guided to assume advocacy roles. Call 23 highlighted the urgency of increasing the number of Indigenous professionals in occupational therapy, and Call 24 identified the need for overtly incorporating learning about how racism, colonialism, power relationships, and historical practices directly perpetuate inequity, poor health, and a lack of safety for Indigenous persons.

Conservatively, five percent of people living in Canada are First Nations, Métis, or Inuit, and the percentage is increasing (Statistics Canada, 2017). The number of occupational therapists in Canada has increased, by 9.2% between 2011 to 2016, and the number of occupational therapists with Indigenous heritage has also grown, from 150 to 230 in that

same period (Statistics Canada 2018a; Statistics Canada 2018b). However, this increased number still accounts for less than one percent of the total number of occupational therapists in Canada, a significant shortfall from the goal of five percent representation, which would more closely reflect the Indigenous population living in Canada.

Collectively, we make a concerted effort to foster genuine and respectful relationships that contribute to our students, faculty, and program moving forward on a path to reconciliation and culturally relevant occupational therapy. Our article title reflects the reality of working in the higher education system with its pervasive and, at times, oppressive, culture of metrification, measurement, and expectation of quantifiable evidence of outputs. In outcome-driven systems, providing metrics allows work to go forward, and so we compiled the following list to capture the “numbers.” Our hope is that those whose perspective privileges quantifiable measures will understand the serious determination and willingness to put in the necessary hard work that faculty members, students, and other stakeholders bring to this journey within our department.



Undertaking (September 2017 to December 2018)	Numbers, measures, and metrics
Indigenous Focus • This is a co-curricular program offering a group of students the opportunity to work to advance awareness of and cultivate skills for culturally safe and relevant occupational therapy (Moon et al., 2018).	10 participating students – 2017 12 participating students – 2018
Hand therapy • Direct service provided at the National Gathering of Elders (2017)	360+ Elders 40+ student occupational therapists 10+ faculty/staff members
Wellness mini-workshops and volunteer activities • Provided at the National Indigenous Cultural Expo (2018)	45+ student occupational therapists and 7+ faculty/staff members working with physical therapy and speech-language pathology counterparts 100s of dancers, drummers, fiddlers, hand game competitors, and others
Guest speakers • Attended meetings of the Indigenous Focus to share knowledge (September 2017 to March 2019)	9 Knowledge Keepers, cultural navigators, researchers, and community leaders
Bannock baking activity • Students made bannock, led by a Métis baker who shared her story about creating a successful catering career and about challenges around securing traditional food sources.	4 dozen biscuits and 1 jar of homemade jam!

Undertaking (September 2017 to December 2018)	Numbers, measures, and metrics
Videos screened and shared <ul style="list-style-type: none"> • Video recordings of Elders' teachings, knowledge holders' presentations, and documentaries were used to further learning. Making careful use of existing resources helps reduce overburdening very busy Indigenous knowledge keepers and Elders who have already generously shared their teachings in accessible digital formats. The list was into a website, Resources for Decolonizing Occupational Therapy, to launch summer 2019: https://cbotlabs.wixsite.com/decolonizing-ot 	60+ videos
Creating a more welcoming environment <ul style="list-style-type: none"> • To create an inviting and culturally safe environment, posters and artwork created by Indigenous artists were installed on classroom walls. 	14 posters (and more to come!), including the 150 Acts of Reconciliation art poster created by Crystal Fraser and Sara Komarnisky: https://150acts.weebly.com/
Fieldwork placements <ul style="list-style-type: none"> • With Indigenous occupational therapists and/or organizations or with occupational therapy services contracted by Indigenous nations 	8 placements and more to come
Faculty lunch-and-learns <ul style="list-style-type: none"> • Sessions have involved taking a strength-based lens to more deeply understand issues such as missing and murdered Indigenous women and girls, performance arts-based approaches to address youth occupational deprivation in isolated communities, and perspectives on queer sexuality and gender expression from Indigenous worldviews. 	12 lunch-and-learns
Co-creation of videos <ul style="list-style-type: none"> • Conducted with an Indigenous client, exploring health-related issues, loss, and culture-related concerns—the case study is incorporated across the curriculum during one term 	40+ students have worked with the case studies on 6 assignments
Bear Witness Day <ul style="list-style-type: none"> • Hosting of a faculty-wide Bear Witness Day (held nationally every May 10) raising awareness about Jordan's Principle: https://fncaringsociety.com/BearWitness 	2 sites 36 bears 175 handouts 4 kilograms of gummy bear candy
Indigenous health and occupational therapy module <ul style="list-style-type: none"> • An optional one-credit module focused on creating culturally reflective occupational therapy informed by Indigenous ways of knowing. The module was co-created and taught by a Métis occupational therapist and University of Alberta faculty. 	43 students completed (2017 to 2018)
Integration across the curriculum <ul style="list-style-type: none"> • Faculty members are working to integrate learning about the historical and ongoing impact of colonization on Indigenous persons' health into the overall program. 	1 example (of many!): The Outside Circle: A Graphic Novel (LaBoucane-Benson & Mellings, 2015)—required reading for all student occupational therapists

The above is a partial list of undertakings; there are many other activities in development. But a list is just a list—opportunities for critical self-reflection and genuine engagement are not captured in a list regardless of the numbers it includes. No list can capture the outward rippling impact created when students share mature, humble, and insightful reflections on racism in health care and in their own lives and talk about how they will take action. This gives us much hope for the future. Equally, no list captures the uncounted, but essential, hours of time and heartfelt goodwill from all stakeholders that go into building respectful relationships that allow for the co-creation of opportunities and experiential learning. As a faculty of predominantly white Canadians of European ancestry, we recognize we will continue to make unintentional racist and uninformed comments when we reach out to Indigenous community members. We try to overtly “own” that and leave our need to

feel in control and secure behind. Instead, we strive to put on the table a genuine invitation to have our ignorance corrected.

The process of decolonizing our curriculum can best be measured in the true metrics of relationship building: warm beverages enjoyed, laughter shared, and hearts opened.



(Image 1: Bear Witness Day/ Jordan's Principle Awareness Event, 2018)

Numbers can tell us where we are and how many people we have built reciprocal relationships with along the journey. These numbers also catalogue samples of our initiatives that can provide an example to others. But at the end of the day, numbers are not relationships, and the outcomes of journeys are not proportionate to the number of activities engaged in along the way. It is the genuine connection and “ah-ha!” moments shared among respectful collaborators that are the true measures of a meaningful shift in our profession.

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The authors teach and research in the Department of Occupational Therapy at the University of Alberta. Our backgrounds are diverse; we aim to act as allies in moving forward against racism and other forms of oppression in a culture that privileges the power of a few over the rights of many. To reach us, contact: cary.brown@ualberta.ca

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The stories we never heard: Honouring the resilience of residential school survivors as a settler occupational therapist.

Heather McDonald

As a geriatric mental health practitioner, I provide consultation in long-term care (LTC) for clients experiencing mental health concerns. I received a referral a few years ago for a client who was showing signs of depression. The LTC providers cajoled this client into eating, firmly suggesting she must come to the dining room for designated meal times, and told her when she should shower. “She’s not cooperating,” they told me. Upon meeting this woman, I began to gently, kindly probe about her early family life, as part of a comprehensive mental health assessment. It felt like picking at a deep wound—once it was exposed, it would be negligent to look away. I sat, near tears, as this woman told me about being removed from her family to attend a residential school. She also shared pride in her resilience and at having raised a family of her own. To her, relocation to LTC was a re-institutionalization and unintended act of aggression; it exposed her to familiar traumas she felt pride in overcoming. I began to see LTC as one more way in which the health care system reinforces colonialism. In this article, I would like to humbly share my reflections on our socialization and education as professionals and on how hearing my client’s story has informed my practice as a settler occupational therapist.

I am a settler who was raised in the traditional territories of the Huron-Wendat and Anishinabewaki. I was educated alongside First Nations and Métis students. We sang “O Canada” in a rotation of English, French, and Ojibwe, which was rare in the 1980s. However, all the proximity in the world would not make up for an education devoid of the truth about residential schools. My education included a Western-informed history of Indigenous Peoples and the colonizers of Turtle Island; the discussion of their intersection was very limited to nonexistent. For example, the negative impact of imperial forces was never discussed beyond the devastation of smallpox. The white chalk marks on the board scratched lies of colonizers’ “brave feats”. We were asked to diligently copy this history into our notebooks, line by line, using them to form a worldview that enables systemic racism. The story of violence and genocide inflicted on Indigenous Peoples was in the black space of the chalkboard. Everywhere the chalk wasn’t, I now see resilience in the face of colonialism. As each was lesson erased and replaced with the next, opportunities were lost daily to discuss what it meant to be a settler on this land. Each omission was an act of harm to Indigenous Peoples inside and outside of my classroom. The narratives from the

chalkboard continued to be present right through to my formal occupational therapy education.

In the spring of 2015, I actively followed the release of the report and calls to action of the Truth and Reconciliation Commission. Reading the document in its entirety, I felt horror as I learned about the forceful removal of children from families, seizing of clothes and cutting of hair, purposeful malnutrition and acts of physical and sexual abuse—abhorrent acts that can be described as nothing short of cultural genocide. I was so moved I brought the TRC’s report to a printer and made dozens of copies for distribution to willing readers. I brought it to team meetings and family dinners, an act of provocation that grew from the emotions roused by the stories it contains.

The following year, when my infant daughter died, I thought of families who lost children to residential schools. The anguish of losing a child became more intimately real. While this experience is not required to build such empathy, I couldn’t help but feel a renewed sadness and urgency with my new understanding of living with loss. I realized simply imploring friends and colleagues to read the report could not make up for the omission of this truth in our upbringing, formal education, and common understanding of what Canada is.

As a quality and research leader on responsive behaviours in the acute care setting, I have reviewed hundreds of policy documents and articles on the topics of dementia and responsive behaviours. Not one has mentioned First Nations issues in LTC. Toronto has the fourth largest (and growing) metropolitan Indigenous population (Statistics Canada, 2017), yet not a single meeting I have attended about LTC in this city has ever included Indigenous voices or perspectives. During the writing of this article, a document was released which included specific mentions of Indigenous issues in LTC (Ontario Health Coalition, 2019), one small opening in an overdue discussion.

I feel deeply troubled by the layers of inequity in the LTC homes I serve—systemic issues of racism, income inequity, and gender inequity plague the provision of quality care. Care providers are often women of colour, usually in unregulated professions without an advocacy association, and many have come to Canada from countries with legacies of colonialism. Where do I begin when I realize we have no shared language? I struggle to find the words and concepts to engage in collegial conversations in response to the TRC, let alone write about them.



My personal and professional experiences have informed the ways in which I've long considered trauma in the care of the elderly, especially as it relates to accepting personal care. My formal occupational therapy education drew on the expertise of a nearby institution renowned for care of Holocaust survivors. There, skilled practitioner educators provided powerful examples of the legacy of the Holocaust, the ways trauma manifests in late life, and how to provide culturally safer care. These lessons influenced my practice process and how I screen and treat all survivors of trauma. However, 15 years on, I wonder why I didn't learn about the health care experiences of Indigenous Peoples, a topic I acknowledge I feel is missing from my knowledge and the scope of this article. I am grateful for the support of Dr. Audrey Giles, who provided feedback as I was revising this article. She shared the article "Health equity, Aboriginal [sic] Peoples and occupational therapy" (Jull & Giles, 2012). I highly recommend it as a starting point to help understand the ways in which the core beliefs we hold as a profession interfere with the provision of culturally safe and equitable health care. Herein, however, lies the problem: when it comes to Indigenous Peoples, even an article co-authored by a friend wasn't on my radar. I see this not only as my own personal knowledge gap, but also as reflective of our professional socialization.

Occupational therapy is a profession historically composed of privileged individuals. Offering culturally safer occupational therapy requires an understanding of living with settler privilege. Our profession must be inclusive of Indigenous perspectives and persons as both clients and providers. I would argue that to do so we must consider the impact of our origins. Occupational therapy grew from a response to violence, treating those who were injured fighting for the colonizing force in the First World War. Though our practice may now look drastically different, the Western worldviews informing our models and frames of reference do not.

While my recent conversations with student occupational therapists and educators alike suggest that the TRC's calls to action are beginning to trickle into the occupational therapy curriculum, we need an active, energetic effort to make up for the generations of occupational therapists before us who did not engage in this education. As a first step, I call on my provincial association to champion continuing education around the findings of the TRC. I would even go further to say we should call on regulatory bodies to require it.

The Honourable Murray Sinclair stated, "We must understand that those who have come through the residential school system are resilient people who deserve our respect, our love and our support" (Lavell-Harvard, Fontaine, & Sinclair,

2017). If we embrace the lessons of the TRC, occupational therapists are well positioned to rise to this occasion. We can help our colleagues understand the impacts of environment on a person with trauma. We can leverage our enablement skills to champion not only services that respect the agency and experience of Indigenous Peoples, but also those they design and lead. Sinclair also stated:

"We will not achieve reconciliation in my lifetime. We will probably not achieve reconciliation in the lifetime of my children. It took us 150 years of colonialism and residential schools, seven generations of people to get to this state. It may take us seven generations to fix it." (Lavell-Harvard et. al, 2017)

I take this not as a message of despair, but a call of hope. We are the generation that can and will begin this change. I believe we must do so with an optimism, energy and vigour reflecting the reality of hundreds of years of suffering. How we respond to the calls to action starts here.

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Knowing from where I respond

Hiba Zafran

response

c. 1300, from Old French and Latin—“answer to, promise in return,” from re- “back” + spondere “to pledge” ... root *spend—“to make an offering,” from the same root as Hittite shipantahhi “I sacrifice” (“Response,” n.d.; “Sponde,” n.d.)

2018

I’m helping Janelle load her car with the Kanien’keha:ka artwork she used to replace the classical portraits at the university faculty club for the launch of Indigenous Awareness Week. Powwow music is vibrating from her car. I’m transported back to being seven years old: my dad is drumming on the dirbakeh, a song about waking, about the morning, and the tune is hauntingly sad. When the Elder spoke earlier that evening at the launch, I saw fidgeting in the audience. Creation myths are not for this place of science. Jessica’s five-year-old daughter was trying to do a handstand on my knees. A Mohawk leader smiled at us. A white woman frowned. Indigenizing academia is going to hurt. I have always preferred the periphery: where will I stand now?

Oppressor

“Something [op]pressed is something caught between or among forces or barriers which are so related to each other that jointly they restrain, restrict or prevent the thing’s motion or mobility” (Frye, 1983).

2003

The department I’m working in is mandated to treat acute psychiatric episodes for Inuit adolescents who are medevacked in from Nunavik. This boy is 16, from an Inuit village, population 1,600, brought in following an attempted suicide. I found out after from the ad hoc case worker that he was brought in from a foster home hundreds of miles south of where his family lives. In rounds, he is presented as a “foster kid who tried to kill himself by hanging—the aim is to stabilize and send him back.” Midmorning of his first day on the ward, he tries to go for a walk on Mount Royal right outside the institution’s doors. He is tackled to the ground by three orderlies and given an injection of Haldol®-Ativan®-Benadryl® when he struggles to get free. At first, I am proud to give him expressive space in occupational therapy. Much later, I begin to understand colonization and the kidnapping of Indigenous children from their families in the 1950s in Nunavik, with families leaving their homes to follow their children south and sit camp outside of residential schools (Truth and Reconciliation Commission of Canada, 2015). I learn about the Royal Canadian Mounted Police slaughtering the dogs integral to Inuit life in the Arctic (Qikiatani Truth Commission, 2013). I learn to see that young man not as trying to kill himself by hanging, but almost

dying by suicide secondary to genocide. I accept that I actively participate in a system that continues to oppress; my own family has been split apart by postcolonial wars and genocide in another part of the world.

Settler

People who go to live in a new country. Synonyms: immigrant, pioneer, colonizer (Collins, 2019).

1998-2003

I immigrate for a Canadian passport. For five years, I live with my boyfriend above the Native Friendship Centre of Montreal. He doesn’t have Indian status due to the two-generation cut off enforced by the Indian Act. He takes me camping in Algonquin territory where descendants of the 1923 signatories of Williams Treaties continue to uphold their hunting and fishing rights. That first morning, when I wake at sunrise and see the river and trees, my heart opens wide. We argue a lot, about his not finishing high school. We break up, and he goes “camping” for 19 months. 13 years later, I walk by and see that the huge mural honouring murdered and missing Indigenous women on the side of our old apartment building has been revamped. Now I understand why he stopped every single day to look at it in silence for a moment. Now I feel the horrors of what school can represent to Indigenous peoples. The inequity of my multiple degrees and current position on land cared for by his people leaves me unsettled.

Bystander

“A bystander is someone who sees an unacceptable act and does nothing to stop it” (Johnston, 2013).

2012-2013

I am two years into navigating a part-time faculty position when Leah, the student representative, brings the importance of decolonization and cultural safety to the curriculum committee. I map out the existing Indigenous content in the curriculum. It is all in the mental health courses that I teach: suicide, trauma, addictions, and community resilience. We have multiple contentious conversations around whether we are practicing cultural competency or safety (Beagan, 2015). At that point, I do nothing to change the reinforcement of psychiatric stereotypes in my teaching.

Ally

An ally is a member of a privileged group who acknowledges historical and current power structures, feels a sense of collective responsibility and the need to learn, and works with oppressed groups (Bishop, 1994).

2018

He is Kanien'keha:ka and has agreed to give a lecture in an occupational therapy course on chronic conditions. Coming from an oral tradition myself, I skip using email and ask if he'd like to meet. He invites me to Kahnawá:ke, a reserve barely 20 minutes from my house, to his mother's restaurant, but after moose hunting season is done. I already know he will offer me a full meal, the cost of which is half the amount he will receive for the lecture. We talk for two hours. He explains that he does not use a wheelchair because he has committed to relearning the healing ways of his people. He has caught a moose, it is a good year. He didn't like the formal lecture format, so he invites the whole class to the Longhouse, with faith keepers present and lunch provided. I am transparent; the university has not approved payment of these "guest lecture" hours, and we will get more than we give. He shrugs—that isn't the point. He wants to engage in his way of knowing. I find a time in the students' schedule and discuss how we will reciprocate.

Accomplice

"The ally industrial complex has been established by activists whose careers depend on ... the struggles they ostensibly support" (Indigenous Action Media, 2019). It is argued that an ally stands with a group, while an accomplice participates in the "crime" of decolonizing structures. Crimes have consequences.

2017–2018

I am engaged in a community consultation process on what graduating occupational therapists should know about Indigenous topics. I have not yet met an Indigenous occupational therapist in Quebec, so I reach out west and virtually meet Angie Phenix and Kaarina Valavaara. I want my colleagues and students to learn with them. I initially have no idea how to make this happen. If they were affiliated with a university, or if I was a research-track professor, then there would be funding...What if you didn't need to have western academic credentials to be considered an expert? I advocate and the proposal is accepted: Indigenous Elders, knowledge keepers, and practitioners will be considered for visiting scholar awards. When I complete my annual performance review, the relationship building will not count toward indicators of merit; the choice had been made to make the results of the consultation openly accessible will count less than a scientific publication.

Warrior

My parents.

About the author

Hiba Zafra is a multiple migrant currently living in Tiohtiá:ke/Montréal. She is an occupational therapist-psychotherapist and assistant professor. She can be reached at: hiba.zafra@mcgill.ca.

2018

I'm standing in the basement of the Dean's house in the Faculty of Medicine. This is where the new Indigenous Health Professions Program is located. Jessica is standing over my contract as a consulting member. It was an unexpected invitation, to be the program's first non-founding member. It is a temporary position and should pave the way for a permanent position for an Indigenous scholar. When I inform my director of the news, she is supportive but also worried: "I don't want you to have your heart broken if the contract isn't renewed." She is not wrong that this could happen; yet, I think of Jessica telling me a story that her Elder's sister, Loretta Afraid of Bear Cook, has told her of the Lakota Tokala warrior society. With one hand they would plant their spears in the ground, and with the other they would fight, holding their line. This is how Loretta sees Jessica's work. I think of how my own parents have held their lineage, our family and values, in and after war. I think of all the lines I am, and will be, pressed to follow, and plant myself firm.

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Together we are stronger: Collective Reconciliation Action

Cara Liane Brown, Margaret Anne Campbell-Rempel, Lisa Diamond-Burchuk, Leslie Johnson, Leanne Leclair, Lisa Mendez, Gayle Restall, Jacquie Ripat

We are white settlers living and working in the city and province with the highest percentage of Indigenous Peoples in Canada (Statistics Canada, 2017). In the past, we experienced feeling overwhelmed and under-equipped to address the injustices that are present in our current societal structure. Today, however, our department is in a place of hope, action, and conviction. Reflections on what created this optimism made us realize that we got here by shifting from individual efforts to collective action as a department. In this article, we share our path to collective action, and our current approach to working together toward reconciliation as a department.

Externally, the Truth and Reconciliation Commission's Report (2015), particularly the health-related calls to action, have been an important element in shaping our path. This report, along with the University of Manitoba Strategic Plan (2015), provided a framework that supported important shifts within the organizational structure of the University of Manitoba that led to the creation of Ongomiizwin, also known as the Indigenous Institute of Health and Healing. Students, faculty members, and staff across five Colleges (Dentistry, Medicine, Nursing, Pharmacy, and Rehabilitation Sciences) in the Rady Faculty of Health Sciences benefit from the leadership and excellence that Ongomiizwin provides in collaboration with First Nations, Métis, and Inuit communities. Ongomiizwin promotes health and healing from the ongoing legacies of colonialism as part of the reconciliation process. Knowledge Keepers and Elders guide the work to promote the health and wellness of Indigenous Peoples.

These structural changes were key facilitators in highlighting our departmental responsibility to engage in reconciliation. They provided opportunities to participate in Indigenous-led activities, and gave our faculty members and students an Indigenous partner organization with whom to do this work. Creating a collective with our colleagues in Ongomiizwin has been essential for our work, as they have patiently guided our learning and reflecting processes. They have given us the gift of their perspectives and stories to support our understanding of how we can engage in acts of reconciliation.

Together our collective has identified four areas of focus for reconciliation for our department, which are described below. Given the importance of relating with and learning from our Ongomiizwin partners on this journey, we intersperse learning moments shared by some faculty members.

1) Ensuring representation of Indigenous Peoples in our profession.

To address the underrepresentation of Indigenous Peoples in the profession of occupational therapy, the Master of Occupational Therapy (MOT) program Canadian Indigenous category comprises 20% of program seats. This percentage was chosen to support proportional representation in our province. Recognizing that designation of seats alone is not enough, we work to ensure that students are able to access supports and resources from Ongomiizwin and other organizations. In collaboration with Ongomiizwin, we continue to scrutinize our admissions processes for bias, and work to create a safe and welcoming environment for Indigenous students during the admissions process. We look to Indigenous communities and organizations, including Indigenous Elders and Knowledge Keepers, to identify ways to support recruitment and retention of Indigenous students within the MOT program. We are eager for Indigenous occupational therapists to join our collective for reconciliation and to lead us in bringing about the change they would like to see.

Learning Moment: After a presentation in which I spoke about Western bias in communication styles, I eagerly asked my colleague from Ongomiizwin, "How was that?". "That was good," my colleague told me, "but I think you could have spoken more directly. Your message could have been stronger." Her words hit me in the heart, as all the moments in my life where I witnessed racism and did not speak up flashed before my eyes ... I resolved to learn how to use my words to be a stronger advocate. CLB

2) Providing safe, supportive and inclusive learning environments.

As a department, we were supported to learn the truth about our colonial history. Through various courses and workshops, we have participated in educational opportunities focused on colonialism, cultural safety, allyship, racism in healthcare, and power and privilege. For example, we participated in San'yas Indigenous Cultural Safety Training (San'yas, n.d.), an online course, and the KAIROS Blanket Exercise (KAIROS, 2013), an experiential learning workshop that provides 500 years of shared Indigenous and non-Indigenous history to foster greater understanding as a key step to reconciliation. In addition to

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The authors are faculty members in the Department of Occupational Therapy in the College of Rehabilitation Sciences at the University of Manitoba, located on original lands of Anishinaabeg, Cree, Oji-Cree, Dakota, and Dene peoples, and on the homeland of the Métis Nation. The authors respect the Treaties that were made on these territories, acknowledge the harms and mistakes of the past, and dedicate themselves to move forward in partnership with Indigenous communities in a spirit of reconciliation and collaboration. Cara Brown can be reached at Cara.Brown@umanitoba.ca.

intentionally integrating this content and learning opportunities into the MOT program, we continue to collaborate with Ongomiizwin and other Indigenous partners to explore other ways to enhance the learning environment and other learning opportunities for faculty members, staff, and students. Guided by the Framework for Research Engagement with First Nation, Métis and Inuit Peoples (Rady Faculty of Health Sciences), we are seeking to learn about the experiences of Indigenous students in our program and to hear their recommendations on how to enhance that experience. Engaging with Indigenous scholars will be integral to these ongoing efforts.

Learning Moment: The KAIROS Blanket Exercise was such a powerful experience for me. Much of the information I learned was new. The experience gave me a deeper understanding of our shared history and has given me both knowledge of and some understanding of the experiences of Indigenous individuals within that history. MACR

Learning Moment: I am roused by the ease with which my colleague from Ongomiizwin is able to challenge people's misconceptions in meetings. We are a profession focused on collaborative relationship building, and at times we opt to move aside rather than pushing through when we encounter the potential for conflict. I am learning that engaging in the journey of truth as allies means this is not a time for gentle prodding, but rather is a time for taking a stand and for making firm demands for change in attitudes and in processes. Watching my colleague instills in me the courage to call out racism, even when it is uncomfortable to do so. LDB

3) Preparing culturally safe occupational therapy practitioners.

We honour Traditional Knowledges and healing practices through the engagement of Indigenous Elders and Knowledge Keepers who share Indigenous Knowledges and perspectives with student occupational therapists. With additional support through a special initiative fund at the University of Manitoba, we will work with an Indigenous Advisory Council to identify what and how Indigenous Knowledges and perspectives should be incorporated into our MOT program.

Learning Moment: Learning about the impact of colonization was such a powerful and visceral experience for me. I felt myself going through denial, then anger, guilt, and embarrassment that I hadn't known better. I am now at a place where I can use my privilege to make way for our students to learn this information too. LM

4) Building collaborative relationships with Indigenous communities.

Faculty members and students have engaged with Indigenous communities and partners in classroom education, fieldwork opportunities, research projects, and advocacy efforts. We have been welcomed into several First Nations communities as we seek to develop our relationships, and have been honoured by the trust that the communities have bestowed on us. These partnerships provide students and faculty members

with invaluable learning experiences, not only in the outcome of the collaboration, but in learning how to collaborate. Our partnerships facilitate critical reflection on occupational therapy and Western theories and frameworks, and on how these theories and frameworks align, and do not align, with Indigenous ways of knowing. We have learned new ways to confront misinformation and racist words and behaviour in our daily interactions.

Learning Moment: Engaging with a First Nation community around development of a playground provided an opportunity for me to practice cultural humility. As I eagerly presented my ideas around accessible play zones that could promote child development, the program director firmly and consistently reinforced that the essential first step was to build an arbour, a sacred open-air structure for ceremony, education, and connection. JR

We recognize the path ahead is long, arduous, and continuous. We are grateful and humbled by the openness of the Indigenous individuals and communities who have allowed us to walk alongside them in the journey toward reconciliation. We acknowledge our responsibility for our own learning, to critically reflect on our own positionality, and to build on the steps we have taken both individually and collectively.

Acknowledgements

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Lessons from two decades of developing a culturally relevant care model

Cara Liane Brown, Rob Diamond-Burchuk, and Lisa Diamond-Burchuk

Rob Diamond-Burchuk is a white settler living in Winnipeg, Manitoba. He is an occupational therapist who began working as a practitioner for a mental health services organization for children and youth in 1997. In this role, he recognized that the needs of many Indigenous youth and families were not being met by the colonial structures and approaches of his employer. This recognition put Rob on a journey of exploring and implementing alternative ways to meet the needs of these families. This journey has required him to be highly reflective on his role as a white settler in supporting the Indigenous community. Over time, Rob's relationship with the Indigenous community has evolved in such a way that his role includes being a link to traditional ceremony for the youth that he serves, and extending beyond the traditional boundaries of occupational therapy practice to being an ally with the Indigenous community. As such, he has needed to contemplate the boundaries between allyship, community helping, community belonging, and appropriation.

Rob sees his ultimate role as encouraging and facilitating Western health providers to guide the youth to the communities who can and will provide the treatment themselves.

Rob's reflections on the lessons about culturally relevant care that he has acquired by learning about and serving the Indigenous community over the last 20 years have provided a platform for discussion for local occupational therapists and occupational therapy students. Lisa and I (Cara) asked Rob to share his 20-year journey for this special OT Now edition on reconciliation in the hopes that it would spark discussion for others across Canada who are seeking to deliver culturally relevant services and are contemplating the complexities of privilege and allyship. We sat down with Rob and listened to his story, and we have retold it here, maintaining it in his own words as much as possible.

The importance of community-based service delivery

Rob's journey began with recognizing the perspective of his Indigenous clients. This helped him to understand the importance of relational continuity and a community-based approach. Rob begins his story by explaining this approach: "One of the best ways to better serve Indigenous communities is to re-orient our service delivery models so that relationships and community are the heart of what we do. I find that many institutions now say they have a goal of serving more Indigenous families, but they don't necessarily examine how

their processes may be barriers for Indigenous Peoples. There are expectations that families will come from their communities to attend our institutions for assessment and intervention, and when these expectations are not met, we discontinue services without examining the underlying reasons.

"Having a clinician embedded in a community has been a better model to serve the communities that I work with. This means not only that the clinician is geographically located in the community, but also that the clinician has developed a relationship with the community. I learned this when I had an opportunity to deliver services out of a satellite office in a community organization in our city's north end. The original intent was to have an Indigenous clinician in that community-based position, but despite the organization's efforts, they were unable to retain one. When I started, youth and families were still not comfortable coming to see me there. I felt strongly that I was still not creating a door for these families, even though I was now located in a geographically accessible location in the community.

"So I started partnering with school and community development organizations, and became a part of the network of community helpers. As I became known, families would get referred to me through this network of helpers. This was a more accessible and safe way for families to access my services than through traditional referral methods, such as waiting on a central waiting list, and then going through an intake and assessment process with multiple providers in an institutional setting. I would get to know families who were not eager to connect with organizations for services, but were open to getting help from a guy who kept coming to their door to provide help—whether that was bringing bunk beds for their kids, or offering to accompany a parent to advocate for the family at a school meeting about their child. My organization at the time did not recognize some of those tasks as a part of my role as a therapist, as the traditional view of a mental health clinician was someone who met with youth in an office for one-to-one counseling, but this work was essential to open up the door for me to connect with these families."

The occupational therapy lens can guide culturally relevant treatment

Another important thing that Rob learned in serving Indigenous youth was how he could use his occupational therapy roots to engage the youth he served. He explains, "My occupational therapy lens has helped me to understand



the value of activity-based therapy for Indigenous youth. The medical model lens puts youth through a process that aims to apply labels like 'ADHD' and provide medical treatment. But often the issues are more about the effects of intergenerational trauma that is a result of colonization and oppression. I realized that the more appropriate service in that context was to establish a relationship with the youth and family, and then assess what was happening by getting to know them and their stories.

"The youth I worked with had a lot of protective defenses that made it difficult for them to engage in talk therapy. They were not comfortable sitting more than 10 minutes at a time, and talking about their feelings and what was going on in their life wasn't working for them. So I started using occupational therapy and resiliency frameworks to develop an approach to meet the needs of the youth through activity. When I first started working with a youth, even if they were not very verbal, they usually could identify an activity in which they were interested. So I took a role in signing youth up for activities and helping them get to these activities. This had multiple therapeutic effects. It showed the youth that they have strengths, promoted resiliency, and opened the door for the development of a therapeutic relationship. When we were driving in the car to these activities, their defenses would be down, and this is when we could do some of the things I usually would be doing in the office, things like processing emotions or building coping skills.

"This idea of activity-based approaches grew into the development of a group that helped out in the community. By becoming community helpers, the activity went beyond individual growth of self-esteem, as it met emotional needs to be socially connected and to have a sense of purpose. Many of the youth I worked with were doing risky things to meet the needs they had for stimulation, or using substances to get high or to escape. The group would do things like help families move, or collect and deliver furniture to new immigrant families. By becoming connected to their community, youth could see other ways to have their needs met, rather than joining a gang or engaging in other deviant behaviour. It was rewarding when youth told us that these community group activities made them feel high, as it showed us that the intervention was helping to show them a different way to meet their emotional needs."

To best serve the community, I developed a relationship with the community

As Rob worked to link youth to culturally relevant activities, his relationship with the Indigenous community grew, and he began to see the benefit of helping youth access cultural activities. "Having a relationship with elders, healers, and mentors from the traditional Indigenous community has been valuable for enriching the experiences of the kids I'm working with. I'm very conscious of being a white settler offering services to Indigenous families, and to make sure that my work was culturally appropriate, I recognized that I needed to support the youth in making more connection with the Indigenous community. Framing mental health service provision with the medicine wheel helped to better align the

services with Indigenous culture and language rather than using settler language and culture. The medicine wheel helps to highlight the importance of spirituality, a component that can be missed in Western approaches.

"And so part of the intervention that I offered was to connect youth opportunities to participate in ceremony and learn to the role of Scabe [traditional helper]. Young people are encouraged to take on the role of Scabe, as it helps to meet emotional and spiritual needs by instilling the value of helping others, allowing them to master skills, and supporting the development of a sense of belonging and identity. Through this work, the youth are also learning about their culture, being exposed to the Elders and to people who are living the traditional lifestyle. They are present to receive teachings, which is a traditional way of passing down coping skills.

"Linking youth with ceremony as a mental health clinician has sometimes been difficult because of bureaucratic parameters. For example, in my role as a mental health clinician, I can only take youth in the community for a few hours, when some of the ceremonies last much longer than that. And although other mental health clinicians will take youth to parks with no special consent in place, for me to take youth to ceremonies, I was required to have individual consent forms completed for each youth and for each event. This means that I can't always facilitate youth to attend an entire ceremony the way I would like to. However, I attend ceremony at the invitation of the traditional community, which allows me to maintain meaningful relationships. This has been important because now I feel like a part of that community and when I hear about a gathering or ceremony occurring, I can facilitate connecting the youth to these experiences. Having this continuity means that I can better link youth with ceremony and has helped me better understand how I can use my relationships with the youth to start to facilitate a connection to traditional ways of being."

I'm still learning how I fit

Eventually Rob's longstanding relationship with the Indigenous community evolved into him being invited to learn about traditional ceremony, and he has been gifted the opportunity to be in traditional helper roles. While he has found that these opportunities have given him a richer understanding of local Indigenous culture, and have been personally meaningful, it has also required him to reflect deeply on his place as a white settler within these ceremonies, and on issues of appropriation when he is invited to share Indigenous culture with the youth he serves. "My role as a Scabe or traditional helper has been another aspect of my training to better serve Indigenous youth. I have trained under Elders and healers to learn about how traditional modalities are aimed at healing the spirit. Just as I would consult with psychiatrist and psychologists for guidance related to medical and mental healing, the Indigenous Knowledge Keepers are a rich source of knowledge related to spiritual healing. One of the ways I understand my role as a 'helper' is in training young 'helpers' as a means of addressing their spiritual needs.

"I am humbled and grateful to have been accepted into a traditional Indigenous community which has patiently taught



me that traditional healing methods are not merely a means of supplementing the Western methods of treatment, but are means unto themselves. I continue to learn about the ways that traditional Indigenous Knowledges can support youth to flourish, and about how to work together with the Indigenous community to act as a link between the colonial health services and traditional healing practices. I am currently trying to understand if and how it is appropriate for me to incorporate some of the things I have learned from the traditional community. For example, I have been told teachings and been encouraged to share them. I recognize that I cannot provide these teachings in a traditional Indigenous way, but it can be helpful for me to support youth in gaining an understanding of this way of learning—that you can build knowledge and teach skills through storytelling and ceremony. In the end, though, it is plain to me that the healing of the spirit for Indigenous individuals is best facilitated by the Indigenous community.”

Advocating with and for Indigenous self-determination in healing

While Rob’s personal practice has involved becoming affiliated with the Indigenous community, he is clear that his experience has taught him that the overall role for occupational therapists is to advocate with and for Indigenous peoples for comprehensive healing practices that are legitimately recognized. Rob says, “Modalities such as teachings, storytelling, and ceremony are incredibly important, but they are not enough. The entire treatment process should be entirely grounded in and guided by Indigenous Knowledge systems and culture, in which treatment is provided not by individuals but by the community as a whole. Ultimately I would like to be a navigator that helps Western medical practitioners direct Indigenous clients to the communities who can and will provide treatment in the traditional Indigenous collective way.”

About the authors

The authors express their gratitude for the opportunity to work, live, and play on Treaty No. 1 territory. **Cara L. Brown** is a white settler and an instructor in the Department of Occupational Therapy at the University of Manitoba and strives to further reconciliation in her role as chair of admissions in that department. **Rob Diamond-Burchuk** is a white settler and has been an occupational therapist for over 30 years. **Lisa Diamond-Burchuk** is a white settler and has been an occupational therapist for 30 years. She has been an instructor at the University of Manitoba for 15 years and practices in a primary care clinic. Please direct correspondence to: cara.brown@umanitoba.ca.

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Responding to the Truth and Reconciliation Commission's report: The University of Toronto experience

Barry Trentham, Janna MacLachlan, Sylvia Langlois, Anne Fourt, Lynn Cockburn, Jill Stier, Ruheena Sangrar, Amie Tsang, and Deb Cameron

The Truth and Reconciliation Commission of Canada (TRC; 2015) called on Canadian university educators to rectify longstanding inequities between settler and Indigenous education and to engage with the reconciliation process. Health care educators are called to recognize the value of Indigenous healing practices and to include information on Indigenous health issues as well as anti-racist and culturally safe practices (see the TRC's Calls to Action 22 through 24). The Department of Occupational Science and Occupational Therapy (OS&OT), at the University of Toronto, with guidance from our Diversity and Inclusion Curriculum Theme Committee (D&I Committee), reviewed our curriculum in light of these calls. While our response has focused on the training of students to engage in culturally safe practice with Indigenous clients, much work has yet to be done on student recruitment and relationship building with Indigenous communities. As with any broken relationship, reparation work can be deeply unsettling and fraught with missteps, but, as treaty people, we recognize that a commitment to reconciliation is imperative. The purpose of this article is to describe the work we have done in response to the calls to action of the TRC with an eye to the work we have yet to do.

Work done to date

The D&I Committee provides leadership on issues of diversity, equity, and inclusion. While it is guided by committed faculty members, student representatives play a significant role in the planning and implementation of teaching strategies that foster both positive student experiences and the knowledge and skill building necessary to make inclusive, anti-oppressive, and culturally safe practice possible. The D&I Committee works to infuse and inform the overall curriculum with an equity lens. Components of the curriculum theme include: a) admissions and recruitment; b) intersectional peer dialogue; c) voices of marginalized populations; d) theories, concepts, models, and practice frameworks; and e) fieldwork and mentorship. While these curriculum components encompass an examination of inequities across numerous equity-seeking groups, since the publication of the TRC's report (2015), greater effort has been made to respond to the impacts of colonialism on Indigenous Peoples (Call to Action 24). We also recognize the need to raise faculty awareness of the historical legacy of colonialism on Indigenous Peoples. For example, faculty members and students participate in the KAIROS Blanket Exercise (see <https://www.kairoscanada.org/the-blanket-exercise-video>), a

participatory history lesson, developed in collaboration with Indigenous people (KAIROS, 2019). Specific examples of our responses to the TRC's report are described below as organized by D&I curriculum theme components.

Admissions/recruitment

The recruitment and admissions process of the Department of OS&OT has been identified as an area that needs closer consideration in terms of how a diversity, inclusion, and equity lens can promote more inclusive outcomes, specifically with regard to increasing the number of Indigenous applicants to our occupational therapy program (Call to Action 23). Currently, no student spaces are reserved for Indigenous applicants. Over the last few years, less than 1% of program applicants self-identified as Indigenous, and despite being offered admission, none of these accepted the offer. The D&I Committee advocated for the inclusion of Indigenous candidates as a priority group and provided input and support for an Indigenous scholarship, which is now established. Additionally, input from the group will inform the efforts of the Ontario Council of University Programs in Rehabilitation Sciences, whose members are identifying factors that influence Indigenous candidate applications.

As the Department of OS&OT is a constituent group within the Rehabilitation Sciences Sector of the Faculty of Medicine, alongside the Departments of Physical Therapy and Speech-Language Pathology, D&I members assist in the coordination of an annual mentorship program for Indigenous and Black high school students. This program aims to give these students an opportunity to explore future careers in health care, including occupational therapy. Over the past two years, 160 high school students have benefited from this program. Space is opened for Black and Indigenous therapists and students to take on leadership roles at this annual event.

Intersectional peer dialogue

Approximately four hours in the first term of the occupational therapy program are dedicated to setting norms and expectations for peer dialogue across social identity differences, a process we refer to as intersectional peer dialogue. Students are introduced to key foundational concepts underlying cultural safety (e.g., intersectionality, privilege, power, historical inequities). They then work through a process of creating classroom norms for facilitating peer dialogue. These sessions prepare students to engage in the



next series of sessions, focused on the voices of historically marginalized social identity groups.

Voices of historically marginalized social identity groups

Students have several opportunities across the two years of the program to hear first-person accounts of how historical disadvantage, prejudice, and discrimination shape everyday occupational engagement. For example, the three-hour Blanket Exercise grounds Indigenous ways of knowing and demonstrates the impacts of colonialism on current-day occupational engagement.

Theories, concepts, models, and practice frameworks

We continue to work toward finding the right balance between providing students with language, concepts, and equity practice frameworks and specific practice strategies. In dedicated sessions, students build on their understanding and application of several key concepts (e.g., anti-oppression, cultural humility, cultural safety). Over the past several years, we have moved from an emphasis on the experience of marginalization, which can lend itself to “othering,” to greater examination of how privilege, in particular white privilege, limits the occupational engagement of historically marginalized social groups. An anti-oppression framework is congruent with the TRC’s call to engage in allyship. Allyship skills are discussed as strategies to advocate in solidarity with Indigenous Peoples for changes to structures, policies, processes, and procedures that are experienced as oppressive (PeerNet BC, 2016). While allyship considers practice aimed at structural inequities, cultural safety and cultural humility are presented as frameworks to respond at the individual, therapeutic level. With the understanding that oppressive structures, attitudes, and norms are traumatizing, students also bring to these discussions their growing understandings of trauma-informed care principles (Clarke, Classen, Fourt, & Shetty, 2014).

Fieldwork and mentorship

Using an anti-oppressive lens, students are supported to engage in critical reflection when debriefing about positive and challenging situations encountered in fieldwork. Panel discussions with therapists and senior students representing historically disadvantaged social identity groups aim to build students’ capacity to deal with challenging situations and dilemmas encountered during fieldwork.

The D&I Committee identified the need for advocacy, networking, and mentorship by and for students and clinicians who identify with historically marginalized communities. This

led to the development of Occupational Therapists for Equity Advancement (OTEA), originally formed by Black, Indigenous, and LGBTQ2+ occupational therapists in the summer of 2018. A website, currently in development, provides a venue for potential mentors from interested groups to share information and contacts.

Reflections and ongoing challenges

As we work toward fulfilling the aims of the TRC, we question how words such as rehabilitation, disability, and therapy are perceived by Indigenous people, as their understandings may be coloured by prior experiences with culturally unsafe health, education, and social systems (Nixon et al., 2015). We remain interested in learning how occupational therapy concepts might be decolonized and reframed by Indigenous Peoples in ways that support culturally safe practice. With respect to Indigenous land acknowledgements that the students hear prior to selected class presentations, we attempt to identify and question our shared meanings of the terms used. We ask ourselves how to make the land acknowledgement more meaningful, so that rather than a rote recitation, it is talk that leads to a “walk.” We also question what it really means to be treaty people and how our understanding impacts instruction regarding occupational engagement.

These questions prompt broader reflection on whose values and knowledge are included in “evidence-based practice,” whose voices are excluded from this rhetoric, and how much work there is yet to do. We continue to adapt course materials, gather resources, and create opportunities to support students in their own critical reflection about how they practice.

Through our activities, we work to practice allyship and critical reflexivity, as well as apply cultural safety, cultural humility, and anti-oppressive and trauma-informed practices, not just in what we teach students, but also in our pedagogies. However, even in writing this, we acknowledge the absence of Indigenous voices on our D&I committee and in this article. We recognize that the roots of colonialism run deep, impacting Indigenous individuals’ participation in curriculum development, practice, and learning spaces. There are many questions we have yet to ask, and we strive to be open to the answers, even when they are difficult to hear.

Acknowledgements

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About the authors

All authors are members of the Diversity and Inclusion Curriculum Theme Committee in the Department of Occupational Science and Occupational Therapy at the University of Toronto. Membership includes graduate students, alumni, and faculty members. For any questions or comments about the article, please contact: b.trentham@utoronto.ca



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An occupational therapy program lays a foundation for Indigenous partnerships and topics

Hiba Zafran, Jessica Barudin, Sara Saunders, Janelle Kasperski

The Truth and Reconciliation Commission (TRC) outlines calls to action for health care professionals and educational programs to engage in reconciliation and to meet the needs of Indigenous communities. The three salient calls for an occupational therapy program are the recruitment and admissions of the inclusion of Indigenous healing practices within the curriculum (#22), recruitment and retention of Indigenous applications (#23), and the acquisition of a critical understanding of rights and anti-oppressive practices (#24) (Truth and Reconciliation Commission of Canada, 2015).

In 2017, McGill University's Occupational Therapy Curriculum Committee prioritized the determination of current evidence and competencies to provide recommendations for developing Indigenous partnerships and topics within the program. This paper's first author, Hiba Zafran, led a mixed-methods appraisal of capacity. This work included consulting relevant communities and building partnerships, reviewing the literature, and mapping local resources. From this work, a report was created about current curricular content and gaps, alignment and concerns in pedagogies, faculty development initiatives, and reflections on informal and hidden curricula to identify recommendations that could lay a foundation for a culturally safe program. As we implement curricular content in 2018–2019, we continue to grapple with the fact that responding to the TRC is so much more than the inclusion of Indigenous health as a topic.

Recent work examining the efforts of Canadian universities has identified three approaches to meeting the TRC calls to action: (1) Indigenous inclusion, based on broad equity principles to simply increase the number of Indigenous students, faculty members, and topics; (2) reconciliation indigenization, focused on establishing power-sharing relationships and acting on shared interests between Indigenous communities and Canadian universities; and (3) decolonization of education, critically reorienting academic processes and structures to truly learn from and with Indigenous paradigms in line with treaty rights (Gaudry & Lorenz, 2018). Inclusion, when not done in a critically conscious manner, runs the risk of becoming a metaphor for inviting and hosting guests at one's home, with invitations being conditional on guests behaving in ways that the host sanctions (Ahmed, 2012). Reconciliation, and the process to achieve it, is going to mean something different dependent on one's positionality and the perceived stakes.

An occupational therapy program must navigate ethical decisions around processes and outcomes for moving beyond inclusion to connect with Indigenous communities and co-create what engaging in reconciliation could mean, and how it deepens occupational justice. With this in mind, our report included seven recommendations based on a critical thematic analysis of the perspectives and experiences of the participants and partners in the process of appraisal. These recommendations are contextualized and justified by policies and various forms of evidence, and are drawn from the range of inclusion, reconciliation, and decolonization principles. Examples of proposed actions for each recommendation are described as follows:

1) Identify and implement curricular content that is socially accountable and promotes justice

"We are concerned that our professional silence makes us complicit in upholding colonial structures and relationships ... that perpetuate the marginalization and oppression of Indigenous [P]eoples." (Restall, Gerlach, Valavaara, & Phenix, 2016, p. 264)

To be able to address health inequities in Indigenous populations, student occupational therapists require a core knowledge of colonial history and the current structures that maintain inequities. If we are to implement content that promotes students' abilities in this area, we must foster a critical socio-historical analysis of occupational models and issues. This content needs to legitimize a "two-eyed seeing" approach, which Mi'kmaq Elders Albert and Murdena Marshall of Cape Breton University defined as referring to a collaborative approach to problem solving that draws on both Indigenous and Western knowledge (CIHR, 2014).

2) Cultivate the guiding principles of cultural safety within the curriculum and school

"Strong communities are born out of individuals being their best selves." (Simpson, 2014, para. 14)

Cultural safety requires going beyond an understanding of Indigenous colonial histories and moving towards questioning one's own power and positionalities within current structures that maintain inequities (Gerlach, 2012). Setting cross-curricular learning objectives and evaluation approaches for critical reflexivity, cultural safety, and political reasoning is a central task that draws on multiple frameworks, notably anti-oppression (Hojjati et al., 2018).



3) Prioritize hiring and working with Indigenous Knowledge Keepers, educators and health care professionals

“I’m doing this work off the side of my desk.” – Statement reiterated by Indigenous educators, occupational therapists, and scholars to the first author

As other occupational therapy programs develop their own content, there needs to be dedicated resources for the development of Indigenous partnerships and topics, as well as for hiring Indigenous educators and Elders in an equitable manner.

4) Promote pedagogies that support storytelling, Indigenous ways of knowing, and transformative learning

“I had to shift the way I think ... I had to stop looking for problems ... I should be looking for stories and to build relationships, otherwise why would they tell me anything?” (amalgam of McGill student occupational therapist quotations following fieldwork in Cree territories)

We need to incorporate pedagogies aligned with Indigenous ways of knowing, prioritizing knowledge creation and sharing that relies on personal experience, on interconnectedness with nature, and on storytelling that is mindful of context, ritual, and ceremony (Battiste, 2012). Knowledge transmission occurs within a framework of values that honour reciprocity, generosity, gratitude, and community in learning (Cajete, 1994). Therefore, the process of learning enacts the content and objectives of learning, with experimental pedagogies that go beyond the cognitive-rational mind to holistic learning (Andreotti, Ahenakew, & Cooper, 2011), and leading to a fundamental shift towards relationship-centred, story- and land-based learning.

5) Enhance faculty members’ critical consciousness in teaching and research

“Until we begin to examine our own culture, we won’t get far with cultural safety.” (McGill occupational therapy faculty member; quotation provided with permission)

The vulnerability of questioning each one’s worldview may come with the fear of losing one’s ground. This fear might be in relation to the critique of occupational therapy philosophies,

or to the reworking of pedagogies or even personal value systems. It is easy to get defensive or resistant (DiAngelo, 2011). As educators, we need to feel safe enough—to have the time, supports, and prioritization by leadership—in order to both learn about and engage with Indigenous communities.

6) Ensure that admissions are equitable and accessible for prospective Indigenous learners

Call to Action 23i: Increase the number of Aboriginal professionals working in the health-care field. (Truth and Reconciliation Commission of Canada)

Equity in recruitment and admissions is a priority in order to increase the number of Indigenous health care professionals. Since 2016, McGill University’s Occupational Therapy program has had two seats designated for Indigenous students with a prior undergraduate degree, yet these seats are not consistently filled. This strategy of designating seats may not be the optimal entry point to support the recruitment of Indigenous-identified students in our context. Socially responsive processes for recruitment and admissions are necessary.

7) Commit to socially accountable and reciprocal partnerships with Indigenous stakeholders, communities, and organizations

“Let Teionkwaienawa:kon ‘working together’ be our guiding principle.” Quebec Indigenous Mentorship Network (QIMN, 2019)

Given the historical and ongoing traumas and mistrust between Indigenous communities and academic and health care institutions, reconciliation cannot happen without building long-term relationships characterized by commitment, respect, and reciprocity. The long view is needed to engage with Indigenous communities in a culturally sensitive, reciprocal, and ethical manner.

By critically engaging in reconciliation efforts and learning with the Cree, Kanien’kehà:ka, Inuit, Algonquin, Anishinabeg, Mi’kmaq, and other First Peoples in Quebec, McGill University’s Occupational Therapy program hopes to become a model of how cultural safety and occupational rights and justice are taught to future practitioners, as well as how these values can be enacted within a program.

About the authors

Hiba Zafran is a multiple migrant currently living in Tiohtiá:ke/Montreal. She is an occupational therapist–psychotherapist and assistant professor (professional). She can be reached at hiba.zafran@mcgill.ca.

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Janelle Kasperski comes from the Nisga’a Nation in the Nass Valley of BC. She is the Indigenous education advisor in the Office of the Provost.

The authors work at McGill University, which is located on the unceded lands cared for by the Kanien’kehà:ka and have long served as a site of meeting and exchange amongst Indigenous Peoples, including the Haudenosaunee Confederacy and Anishinabeg nations.

In line with the ethos of collective and accessible knowledge, the complete report is available for consultation by contacting: hiba.zafran@mcgill.ca.

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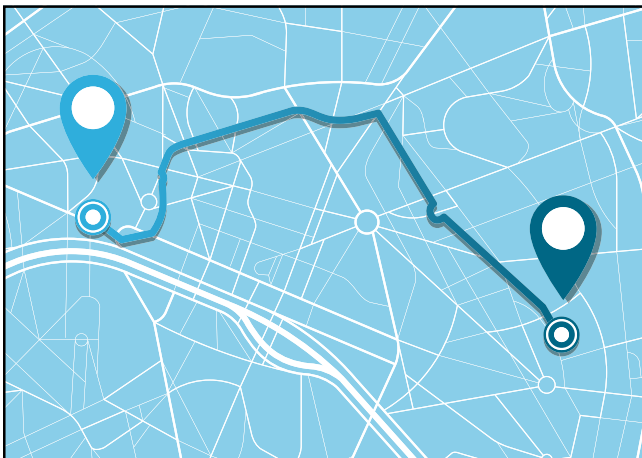
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