Exploring the Experiences of Indigenous Occupational Therapists in Canada

By

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Dalhousie University is located in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq. We are all Treaty people.

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ABSTRACT

Introduction: The occupational therapy (OT) profession is derived from colonial ideologies, and despite recent efforts to address the Truth and Reconciliation (TRC) Calls to Action and address systemic racism, the profession must consider the value of and need for other worldviews and ways of knowing. Indigenous occupational therapists are well positioned to engage in and lead this work – yet many Indigenous OTs experience a lack of belonging and a poor fit between their own ways of knowing and the profession. As such, Indigenous occupational therapists have identified a need for a dedicated community of practice (CoP). Methods: Stage 1 of this research project utilized individual storytelling sessions (n=13) with Indigenous OTs to learn more about their everyday experiences, whereas Stage 2 consisted of an in-person sharing circle gathering (n=8) to collectively generate advice and ways forward for the profession through the formulation of an Indigenous CoP. Implications: Indigenous OTs shared their everyday experiences of working in the colonial OT profession contributing to forming a needed knowledge base within the literature. An Indigenous CoP will provide a dedicated space for Indigenous OT students and therapists to consider the strengths of both Indigenous ways of knowing and Western knowledge working together (Etuaptmumk/Two-Eyed Seeing) to improve the profession as well as providing needed support and mentorship to one another. Conclusions: This CoP will help inform the occupational therapy profession regarding needed supports and changes to begin fulfilling the TRC Calls to Action.

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CHAPTER 1: INTRODUCTION

Indigenous Peoples have lived on the lands of Turtle Island for millennia – practicing their cultural traditions and ways of knowing, being, and doing to survive and thrive. Indigenous perspectives have been, through policies, programs, and services, deliberately excluded from the mainstream narrative despite the value these perspectives hold for improving and addressing broad societal challenges. We are currently experiencing grave health, societal, and environmental challenges – and the richness of Indigenous ways of knowing are one way to begin addressing challenges that mainstream knowledge and narratives have not been able to address to date. More specifically, Indigenous Peoples have maintained their own self-sustaining health and wellbeing practices that have supported their Peoples, and it is critical to include these Indigenous practices and perspectives to improve health – not just for Indigenous Peoples, but for everyone. Indigenous ways of knowing, being, and doing can inform how to live in a good way, how to find meaning in our daily lives through connection to language and culture, and how to live in harmony with all things to ensure sustainability of our resources. It is these epistemologies and ways of being and doing that must be utilized and valued in the current health care system to support addressing the complex health challenges our Peoples and communities face today.

Yet, Indigenous Peoples experience poorer health outcomes in comparison to other people in Canada and have traditionally experienced difficulties accessing culturally appropriate/suitable health care services for a variety of reasons (Allan & Smylie, 2015; Etowa, Jesty & Vukic, 2011; Latimer et al., 2020; Smith et al., 2011; Macaulay, 2009). A

growing body of evidence points to systemic racism and colonial worldviews within the health care system as barriers to Indigenous Peoples seeking care, but little research has explored the experiences of Indigenous health professionals, and their experiences working within a colonial health care system. Nor have researchers sought out their ideas for change. By gaining an understanding of these everyday experiences, a discussion can begin surrounding changes that might be made to education and work environments to create a more welcoming, supportive context for Indigenous students and professionals.

The Truth and Reconciliation Commission (TRC) Calls to Action state the need for recruiting and retaining Indigenous health care professionals as well as fostering health care spaces that respect and value Indigenous knowledges in the context of health (TRC, 2015b). Better understanding the everyday experiences of Indigenous professionals may help to address their consistent under-representation in the health professions broadly (Smith et al., 2011), and within occupational therapy specifically, in turn making needed changes to a profession grounded in Euro-Western ideologies and notions of white supremacy. These foundations have resulted in numerous challenges for Indigenous Peoples – including poor health care experiences and a lack of understanding by clinicians in relation to Indigenous ways of wellness. This is exacerbated when Indigenous Peoples are underrepresented in post-secondary health professions programs as this results in a workforce that is largely made up of non-Indigenous clinicians. The value of having Indigenous clinicians in all areas of health care cannot be understated in the context of providing care that is culturally safe and derived from Indigenous worldviews.

Thus, not only are Indigenous Peoples marginalized when they access care, they are also marginalized in health care roles.

However, these Calls to Action are situated in a complex history of Indigenous and settler relations on Turtle Island. For centuries, Indigenous Peoples have endured purposeful genocide and assimilation from settlers to the region (Allan & Smylie, 2015). Despite the ongoing damage caused by this, Indigenous Peoples have been resilient and resourceful – continuing to practice their own traditional cultural, ceremonial, and social practices. However, health and social inequities are ever-present for Indigenous Peoples in the context of colonial Canada (Allan & Smylie, 2015; Reading & Wien, 2009). More specifically, the health care system itself within Canada has been described as colonial, grounded in Euro-Western worldviews. Consequently, many Indigenous Peoples experience racism and discrimination when trying to access services, ensuring the health inequities experienced by Indigenous Peoples continue.

The health care system is almost entirely reliant on post-secondary institutions in Canada continually educating and training health professionals to staff health provider positions. It is not surprising that, like the health care system, post-secondary institutions in Canada have been derived from Euro-Western ideologies, values, and assumptions – acknowledging this, and moving away from it, has proven to be challenging. The health professions are engulfed in colonial settler epistemologies given their inception within Western biomedicine and continued strict practice regulation and policing of entrants into the professions. Both the post-secondary education system and the health care system in Canada have been implicated in colonialism and the deliberate exclusion of

Indigenous Peoples. As one such health profession, occupational therapy is a field of practice that helps clients solve problems and address barriers to engaging in occupations they want and need to do (CAOT, 2016c) such as going to work and engaging in leisure activities. The profession has been implicated in historical events such as Indian Day Hospitals (Meijer Drees, 2013) as occupational therapists treated Indigenous patients sent to these hospitals and has been described as a profession heavily grounded in Euro-Western worldviews (Grenier, 2020; White & Beagan, 2021). The profession in Canada has declared commitment to improving Indigenous health and supporting reconciliation and decolonization efforts (e.g., ACOTRO, 2022; CAOT, 2016a/2018a), as well as a pointed commitment from CAOT to addressing the TRC Calls to Action through the creation of a TRC Task Force (CAOT, 2016a). The Calls to Action that are particularly relevant in this context include but are not limited to: #7 (eliminating education and employment gaps for Indigenous Peoples), #22 (the need to recognize and value Indigenous healing practices and use them) and #23 (recruitment and retention of Indigenous health care professionals and cultural safety training for all health care professionals). While Indigenous clients of occupational therapy services would have a vital vantage point to assess decolonizing efforts, this is also true of Indigenous therapists. Therefore, to truly make good on the profession's commitments to Indigenous health and decolonization, it is important to explore the perspectives of Indigenous OT practitioners within the profession.

My PhD research

The research question that guided this work is: *How do Indigenous Peoples experience working as occupational therapists in Canada?*

My work explored the following sub-themes:

1. How everyday work experiences of Indigenous OTs were shaped by their Indigeneity in the context of a colonial profession;
2. How Indigenous OTs employ Etuaptmumk [Two-Eyed Seeing] (Bartlett, Marshall & Marshall, 2012) in their everyday practices;
3. How the social processes of inclusion and exclusion influence their practice;
4. How professional context shapes experiences of belonging and marginality; and
5. How Indigenous OTs advise the profession in change efforts, ranging from Indigenous inclusion towards actual decolonization (Gaudry & Lorenz, 2018)

These sub-themes have been framed around the assumption that anti-Indigenous racism and colonialism are pervasive within the health professions. Framing these questions as "how" rather than "whether" invites the exploration of complex nuances rather than close-ended yes/no answers.

My doctoral thesis research explored the perspectives and experiences of Indigenous occupational therapists but is part of a larger national qualitative study (PI Beagan, co-I's Martin, Etowa, Owen, and Macleod, 2019) exploring the experiences of professionals who may experience marginalization due to Indigeneity, racialization, ethnicity, social class background, disability and/or LGBTQ+ identity. Beagan and Martin are co-supervisors of my doctoral work. An earlier SSHRC-funded study (PI Beagan)

examining processes of professional disclosure and social exclusion in three other professions (academics, social workers, and lawyers) suggested issues of competence, patient safety, and boundaries between patient and provider shape a unique context for social exclusion in the health fields. This work provides a critical grounding of equity-seeking experiences within the professions broadly as well as the health professions specifically to support the needed exploration of Indigenous occupational therapist (OT) experiences. What is distinct for Indigenous therapists is that they are working 'between two worlds' – being employed in the context of a colonial systems while also drawing on their own cultural grounding and ways of knowing, being, and doing. In the context of the professions as well as the educational trajectory to get into the health professions, working 'between two worlds' is something Indigenous therapists may have experienced for many years. Given the distinct governance system for health care, and the strict regulations of health professions specifically, this working between two worlds provides unique insights into needed changes to our health care and education systems. With a commitment to *Etuaptmumk* (Bartlett, Marshall & Marshall, 2012), this research employed Indigenous methods of participatory research, including storytelling, and sharing circles (Archibald, 2008), as well as aspects of critical autoethnography (Ellis, 2004).

Indigenous occupational therapy community in Canada

The Indigenous occupational therapy community is small. I know approximately 10-15 OTs who self-identify as Indigenous; however, I am aware based on census data that there are more I do not yet know. Further, the historical lack of Indigenous specific

or even race based data collected by regulatory bodies poses a barrier to better understanding the workforce. Nonetheless, with academic institutions focusing on equitable admissions and diversity initiatives, I am anticipating that more Indigenous OTs will be entering the profession in the coming years. Many of the Indigenous OTs I know are working in areas relating to Indigenous health and wellbeing or working directly with Indigenous clients and communities. Many experience a divide between their own Indigenous cultures and values and those of the occupational therapy profession. Further, many of us have identified an overarching goal of holding the profession accountable regarding declared commitments to advancing Indigenous health and fulfilling the TRC Calls to Action (TRC, 2015b), while also taking the initiative to create an Indigenous Community of Practice (CoP). The goals of this emergent CoP, as presented at the 2021 Canadian Association of Occupational Therapists (CAOT) Conference (White et al., 2021), are to provide Indigenous occupational therapy students and therapists a dedicated space to explore how to align Indigenous ways of knowing and lived experiences within occupational therapy, provide and receive mentorship, and raise the profile of occupational therapy within Indigenous communities. At a later date, we envision that this CoP will also be able to provide consultation, advocacy, and education to settler occupational therapists from a place of collective strength and wisdom. Overall, this CoP will ideally ensure Indigenous OTs entering the profession feel supported, valued, and a sense of belonging – experiences that many Indigenous OTs I have spoken with did not feel upon entering the professional workforce. The work that I do in this research project is derived from, and grounded in,

my own experiences as well as the experiences shared with me by my colleagues and friends.

My relation to the research

It is important to situate myself and my story within this research project. I have grown up in Nova Scotia my entire life with my mother, father, and 2 younger sisters. My father was placed into foster care as a very young child (under the age of 1) into a white family and spent much of his life unaware of his biological family. Later in life, he began to explore the circumstances of his foster care placement and found out soon after that he was Mi'kmaw and a member of Sipekne'katik First Nation. This led, over many years, to discovering numerous family members – many of whom I am building relationships with at this time.

When I was younger, I had a keen interest in learning more about my family, as well as Mi'kmaw culture – something I was never afforded the opportunity to do given the severing of family ties when my father was placed into foster care. All of his siblings were adopted into different homes, scattered across Canada. Many of his siblings experienced trauma in their adoptive homes, and others attended residential school at a young age. I feel fortunate that my grandmother (my father's foster mom) was chosen for him. She was kindhearted, genuine, hard-working, and a major influence in my life, despite not being my biological grandmother.

During junior high and high school, I was fortunate enough to be connected with an Indigenous Student Support Worker who understood the context of my life and allowed me to discover more about myself and Mi'kmaw culture than I could have ever

imagined. This curiosity continued into my undergraduate degree, however not many options for courses on Indigenous health and wellbeing were available or accessible to me. My Masters degree and subsequent PhD studies have allowed me to develop meaningful, supportive relationships with Indigenous Peoples and communities. I have learned more about myself as a Mi'kmaw woman through these experiences than I could have ever done on my own. I am grateful for the relationships with Indigenous students and scholars who have guided me and supported me in my journey of learning more about myself and Mi'kmaw culture.

Nonetheless, I have also been exposed to the myriad ways that Indigenous Peoples are mistreated, excluded, and undervalued in the context of the academy, as well as society broadly. These experiences – some I have experienced first-hand whereas others have been shared with me – are the driving force behind my work as an occupational therapist. Since the beginning of my Masters in OT degree, I have connected with other Indigenous OTs across the country. Many of them have become close friends and confidantes. Many share similar ideas and visions of working in a system that has been implicated in the inequities Indigenous Peoples experience. I am passionate about finding ways to improve the occupational therapy profession through the valuing of multiple perspectives and ways of knowing – and I truly believe that the profession has a lot to learn from Indigenous Peoples, communities, as well as the Indigenous practitioners within the profession. This research is the first in Canada to explore the experiences of Indigenous occupational therapists.

CHAPTER 2: LITERATURE REVIEW

In this chapter I review existing literature regarding inequities in health and health care experienced by Indigenous Peoples, the positioning of Indigenous Peoples within health professions education (which begins more broadly in post-secondary institutions), and colonialism as a specific mechanism of exclusion within the health professions. I identify a framework for thinking about change efforts in post-secondary education, ranging from inclusion to reconciliation to decolonization, detailing what each of those means. I briefly review literature on the experiences of Indigenous Peoples within the health professions, contextualizing that within the history and potential of occupational therapy specifically, then synthesize the scant evidence about experiences of Indigenous OTs.

Indigenous health and wellbeing in the context of Canadian healthcare

Indigenous Peoples on Turtle Island (Canada)

For centuries, Indigenous Peoples on Turtle Island (now named North America) have been living a traditional lifestyle derived from their own cultural, ceremonial, and health practices. This way of living sustained Indigenous Peoples and their health and wellbeing and allowed them to survive and thrive on the lands and waters of the territory since time immemorial. Indigenous Peoples have been incredibly resourceful and skilled in ensuring the health and prosperity of their communities, which began to change dramatically upon the first point of contact with settlers (Europeans) coming to the region. Indigenous Peoples occupied Turtle Island for well over 60,000 years prior to first contact with early European explorers in the 11th century (Steeves, 2021). However, the

lives of Indigenous Peoples and their communities changed drastically over the coming centuries as Europeans settlements increased into the 16th and 17th centuries. Europeans proceeded to claim resources and land within the traditional territories of Indigenous Peoples in many cases - in spite of the obligations and responsibilities promised by formal Treaty relationships.

Settlers to the region caused disruption to traditional ways of living for Indigenous Peoples through practices such as land ownership and permanent settlements, imposition of Christianity, differing trading routes (Aboriginal Affairs and Northern Development Canada, 2013), and generally through the domination of European ways of knowing, being, and doing – cultural imperialism (Smith, 2018). Settlers brought numerous, novel diseases to the region which caused detrimental health and social impacts for Indigenous Peoples (Aboriginal Affairs and Northern Development Canada, 2013). Further, in many instances, Indigenous people were purposely denied treatment even when treatment was available for these diseases – contributing to the overall genocidal agendas of the Canadian Government (University of Victoria, 2002). Over the coming years, the relationship between Indigenous Peoples and settlers to the region deteriorated, with settlers aiming to take over the region and its vast resources (termed colonialism) while forcibly removing, assimilating, or attempting to eliminate Indigenous Peoples to accomplish this (Matheson et al., 2022; Smith, 2018). The colonial project was enshrined and executed through practices such as the Indian Act, the Indian Residential School System, and the 60's Scoop, while also utilizing more subtle ways of assimilation through cultural imperialism and white supremacy (Allan & Smylie, 2015; Smith, 2018).

This caused mass disruption and led to the severing of Indigenous Peoples from their traditional ways of living, breakdown of communities, and rampant diseases previously unseen in the region. These acts of colonialism and paternalistic control over Indigenous Peoples have led to health inequities for Indigenous Peoples that continue today (Allan & Smylie, 2015).

Indigenous health inequities

Despite the fact that Indigenous Peoples have been actively fighting against colonialism and the purposeful assimilation and genocide of their people, Indigenous Peoples continue to be plagued with forceful assimilation into Euro-Western worldviews and practices (Smith, 2018). One does not need to look far to find statistics on how Indigenous Peoples are described as having difficulty accessing basic necessities such as secure and quality housing (National Collaborating Centre for Aboriginal Health, 2017), struggles with obtaining clean drinking water (Human Rights Watch, 2016), food insecurity (Chan et al., 2019), and inadequate access to health care services and programs (National Collaborating Centre for Indigenous Health, 2019). All of these inequities directly contribute to lowered socioeconomic status (SES) (Adelson, 2005) of Indigenous Peoples in Canada. These inequities are rampant in mainstream media discourse and have direct impacts on the health status of Indigenous Peoples (McCue, 2014). Yet, what is often lacking in the discussion are the underlying reasons behind these inequities, creating a narrative of victim blaming and Othering, while ensuring the government and the colonial practices and economic systems remain unquestioned and uninterrogated.

When we begin to explore the broader social, health, and economic conditions of Indigenous Peoples in Canada, it becomes clear that Indigenous Peoples are not given equal resource investment compared to the rest of the population (Commission on the Social Determinants of Health, 2008). This lack of sufficient investment in needed resources has a direct impact on access to opportunities and materials needed to survive and thrive. Therefore, it is important to make clear that the inequities experienced by Indigenous Peoples are a direct result of colonial influence – meaning the colonial events, policies, and practices that have been created by, and for, settlers to Canada. Examples of harmful and deadly colonial policies and practices can easily be seen from the Indian Act of 1876 (Henderson, 2006) to the child welfare system, where Indigenous children are disproportionately both over-represented and underfunded (Fallon et al., 2021). These policies, practices, and programs are founded on colonial ideologies and are a tool for the continuation of white supremacy in Canada where the superiority of white people and subsequent subordination of Indigenous Peoples continues a cycle of genocide, racism, and discrimination (Allan & Smylie, 2015; Smith, 2012).

Distal determinants of health are those that are deep rooted, structural, and often go unnoticed in their impacts on health and wellbeing (e.g., colonialism or racism). They are described by Reading (2015) through the visual depiction of a tree. The roots of the tree form the distal determinants, and thus impact the health and wellbeing of the tree, despite not being seen. As such, it is not surprising that colonialism is noted as a distal determinant of health for Indigenous Peoples (Czyzewski, 2011; Reading & Wien, 2009), impacting the proximal (e.g., educational attainment, rates of chronic diseases)

determinants of health for Indigenous Peoples in complex ways as well. It is important to make explicit that Indigenous Peoples have been impacted by colonial policy making, making them less likely to be able to work and earn a modest living, attend school, and excel in Western education systems. All of these things impact health and wellbeing, and when we consider this along with the fact that Indigenous Peoples have difficulty accessing health care that is relevant, culturally-informed, and free of discrimination – the inequities in health and wellbeing experienced by Indigenous Peoples are the structures of colonialism.

Inequities in health care for Indigenous Peoples

Within the Canadian health care system, the inequities created by historical and current practices of colonialism are increasingly discussed (Allan & Smylie, 2015; Horrill et al., 2018). Indigenous Peoples have inadequate access to needed health care services (National Collaborating Centre for Indigenous Health, 2019). When they can access needed services, they often are met with systemic racism and colonial worldviews (Lowrie & Malone, 2020; Paradies, 2016), which lead to services that are unsuitable and can even be harmful (Allan & Smylie, 2015), or deadly (see, for example, Geary [2017] or Page [2021]). Ironically, the health care system within this country is known around the world as being founded on principles of inclusiveness and multiculturalism and is cited for its universal health care access – yet Indigenous Peoples and their health status indicators do not match this description of equitable care and access for all (Gionet & Roshanafshar, 2013). Therefore, it is important to contextualize the inception of the health care system here in Canada to gain a better understanding of the reasons behind

the inequities experienced by Indigenous Peoples alongside their experiences of racism, discrimination, and alienation.

The Canadian health care system has been founded on and derived from colonial ideologies, representing the worldviews and values of the dominant Eurowestern population (Horril et al., 2018). For example, this is seen in health care through the predominant focus on illness rather than wellness. Despite its emphasis on multiculturalism and equity, the health care system represents a relatively narrow view of health and wellbeing derived from Euro-Western worldviews (Denzin & Lincoln, 2018; Shaheen-Hussain, 2021). Given the complex and oppressive history between settlers and Indigenous Peoples, it is not surprising that Indigenous conceptualizations of health and wellbeing, along with their traditional ways of sustaining health, are entirely absent in the formulation of health care as we know it today (Denzin & Lincoln, 2018). Structural racism is present in the health care system and has deep and long-lasting impacts for Indigenous Peoples who seek health services and supports (Allan & Smylie, 2015). Racial discrimination further contributes to the health inequities Indigenous Peoples already experience – creating conditions of avoidance, fear, the internalization of discrimination and stigma (Allan & Smylie, 2015; Browne et al., 2011; Pilarinos et al., 2023) as well as generalized increased vigilance when accessing services (Stuber et al., 2008).

Given that the health care system is colonial in nature, it is designed to fit and meet the needs of the Euro-Western population. This also means that the overwhelming majority of those who work as health care service providers are also members of the Euro-Western population. This has resulted in a health care workforce that is dominated

by settlers (Wilmot, 2021) and that ignores and undermines the value other individuals from diverse backgrounds or communities contribute to the conceptualization of health within the health care system.

Composition of the health professions

Although in recent years the make-up of the health professions has been changing, the health care workforce still resembles a sea of white faces. The healthcare workforce is a main employer for many – however, Indigenous health professionals make up roughly 13,000 providers – a mere 1.2% of the health professional workforce (University of Saskatchewan, 2017). Statistics Canada (2016a) notes that there are 8,855 Indigenous registered nurses (2.95%), 215 Indigenous OTs (1.4%), and 760 Indigenous physicians (0.84%) in Canada. However, it is important to recognize that these numbers should be taken with caution as some may not self-identify. Nonethless, these numbers are far from the percentage of people who identify as Indigenous in Canada, which is roughly 5% (Statistics Canada, 2016b).

The foundation of our health care system is in part responsible for the rampant discrimination and harmful service experiences by Indigenous Peoples, however, it is also compounded by the fact that the health professions have been a guarded, elite 'club' for decades (e.g., Beagan, 2005, 2007; Gorman & Sandfur, 2011). The lack of representation of Indigenous Peoples in these practitioner roles has contributed to colonialism and racism continuing within the health care system. In recent decades, these statistics and experiences from Indigenous Peoples have spurred outcries and inquiries to determine ways forward for change and reconciliation. Notably, so often the government has not

acted until there are crises within Indigenous communities that no longer can be ignored. In 1996, The Royal Commission on Aboriginal Peoples was established to facilitate improved relationships with Indigenous Peoples and the government (RCAP, 1996), and in 2007, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) was brought forward to protect and ensure the rights of Indigenous Peoples are respected (United Nations, 2008), although Canada delayed formal endorsement until 2016 and did not officially sign until 2021 (Duncanson et al., 2021). These major documents and events paved the way for further, more targeted inquiries such as the Truth and Reconciliation Commission (TRC) of Canada (final report released in 2015) to support those impacted by Indian Residential Schools (TRC, 2015a). The TRC Calls to Action (TRC, 2015b), released as a standalone report from the inquiry, cover topics ranging from justice, language and culture to health. Call to Action #23 focuses directly on increasing the number of Indigenous health professionals and ensuring retention of those professionals: "We call upon all levels of government to: Increase the number of Aboriginal professionals working in the health care field." Another inquiry, the Missing and Murdered Indigenous Women, Girls, and 2-Spirit People (MMIWG2S) to interrogate the disproportionately high rates of missing and murdered Indigenous women, girls, and 2-spirit people, released a report in 2019 (MMIWG, 2019) that outlines needed Calls to Justice, such as Calls 3.1-3.7 which focus on health, wellness, and the need for culturally appropriate and accessible services.

Despite the contextual information on colonialism in Canada, it is not surprising how the composition of the health care system, and subsequently, the current climate

for Indigenous Peoples within that system, continue to be so unjust. The inequities in Indigenous representation mentioned above are, at least in part, derived from a legacy of colonialism within post-secondary institutions; efforts to ensure recruitment and retention are complicated by the context of a colonial post-secondary education system. Therefore, as per Call #23 of the TRC urging the increase and retention of Indigenous health professionals, the pipeline into the professions must be considered. Recruiting more Indigenous health professionals starts with recruiting more Indigenous learners into post-secondary education institutions and improving the content of Indigenous health curriculum within health professions education. These are issues that pervade the education system in Canada.

Post-secondary institutions as gatekeepers to the health professions

The inception of post-secondary institutions

Although numerous variations of post-secondary institutions have been operating for well over a hundred years, during the era of the 19th century, the overwhelming majority of post-secondary institutions in Canada were linked to theology and liberal arts (Sheehan, 1985), and more generally, religion (Usher, 2018), making the oldest universities in Canada almost entirely founded on notions of Christianity and sectarianism (Usher, 2018). Educational institutions during this time were created for white men of middle to upper class status, with bigger institutions such as McGill and the University of Toronto grappling with the idea of potentially letting (white) women attend and obtain an advanced education (Sheehan, 1985).

Therefore, it is not surprising that universities at the time have been called social gatekeepers, with race and class being among the defining features determining admission (Sheehan, 1985). This meant that for decades, obtaining a post-secondary education was out of reach for many due to their class, gender, age, or religion (Sheehan, 1985) and these underlying ideologies of who is worthy of receiving a post-secondary education can be difficult to change. Some of this changed during the 20th century when institutions began being funded by their respective provinces, with support from the federal government (Usher, 2018). Nonetheless, obtaining a post-secondary education was still a guarded space, meant for those who 'fit' a particular societal mould. Although the governing of institutions based on religion and religious affiliation is mostly a thing of the past for major public institutions in Canada, these institutions are still founded on the idea of *exclusion* (rather than inclusion) of diverse peoples. Despite universities now claiming to be inclusive and welcoming spaces for all, experiences from those who have entered from diverse backgrounds point to tensions between their lived experiences and the universities' current declared commitments to equity, diversity, and inclusion (Universities Canada, 2017). This is particularly complicated for areas of post-secondary study such as the traditional professions and the health professions – which are derived heavily from settler (colonial) ideologies and continue to struggle with disconnecting from their origins due to strict regulatory policies and practices that outline how, and what, practice can, and should, look like.

The history of the health professions

The traditional 'professions' such as medicine, law, and accounting have long held elite status as the custodians of expert knowledge in society (Gorman & Sandfur, 2011). Those who entered into a profession were awarded other advantages such as economic, social, and cultural capital (Gorman & Sandfur, 2011). One of the defining features of the traditional professions was their ability to self-govern and hold significant autonomy to dictate and regulate their own professional expertise and boundaries, with sponsorship from the elite members of society being the final check point into a classification of 'profession' (Macdonald, 1995).

The notion of what classifies as a profession has changed over the years, from the traditional professions of law, medicine and architecture, to include what were once considered 'allied professions', such as the inclusion of nursing and occupational therapy. The professions and concept of professionalism have over time become heavily intertwined with dimensions of gender, race, and social class (Chua & Clegg, 1990; Martimianakis et al., 2009). Each profession must establish its own claims on knowledge and expertise, exercising that authority, clearly articulating and maintaining the boundaries of their profession in comparison to others (Fournier, 2000). These boundaries clearly demarcate where the profession begins and where it ends, affording its members expert knowledge and elite memberships, described as 'social closure' (Macdonald, 1995; Nancarrow & Borthwick, 2005). For members of a profession, this is usually thought of as 'scope of practice', identifying the boundaries of their own 'turf'. through legal definitions as outlined in respective provincial legislation. The notion of social closure includes creating conditions to determine who can and cannot enter the

profession, a process highly influenced by colonialism and the social groups who were afforded the opportunity to explore and be a part of the professions. Although numerous other fields have been afforded professional status (e.g., nursing, physiotherapy, occupational therapy) over the years, this professional status has allowed these professions to be part of an elite, exclusive 'club'. As such, the professions play a role in the perpetuation of colonialism.

Colonialism: A defining feature

Colonialism is defined as "a practice of domination, which involves the subjugation of one people to another" (Stanford Encyclopedia of Philosophy, 2006, para. 1). One cannot discuss the evolution or the inception of the health professions without making a clear link to colonization and subsequent colonialism during that time. When settlers arrived in the region we now call Canada they took control over the territory and proceeded to bring their diseases, laws, governments, religions, economic systems, and systems of surviving along with them, a process called colonization (Smith, 2018). Treaties promising peaceful co-existence were disregarded by settlers. With the ways of knowing, being, and doing of settlers imposed and becoming dominant within the territory over centuries, the traditional occupants of the land, Indigenous Peoples, were entangled in a struggle to maintain their ways of living, their lands, and their languages in a rapidly changing society.

As professions were being created and developed, they were entirely founded upon colonial rules, structures, beliefs, values and ideologies (Horril et al., 2018). Settlers created their own society and boundaries and kept Indigenous Peoples, as well as anyone

else who did not fit into their normative societal structure, on the margins. This resulted in defining features of the health professions – along with concepts of professionalism and professional boundaries – being entirely engulfed in settler epistemologies, leaving health professions education and practice as a site of marginalization for those from diverse communities and backgrounds. What follows is an exploration of influential concepts that have supported the formulation of the health professions for decades and are still employed in policing them. It is important to keep in mind the biases and underlying assumptions built into the professions operate as a site of exclusion and marginalization for those whose identities and social positions (e.g., class, gender, race, etc.) do not line up with the 'ideal' created and conceptualized within Euro-Western societies – thus reinforcing an 'insider' and 'outsider' dynamic.

Elitism in the health professions

Professions have been understood as jobs that involve altruism, and service to the society within a defined field of expertise, and accompanied by authority and social prestige (Macdonald, 1995). The 'ideal' health professional was thus constructed as altruistic, self-sacrificing, highly motivated toward public service, experiencing their work as a 'calling' not just a job, compassionate yet detached and objective (e.g., Crow & Burgha, 2018; Traynor & Buss, 2016). At the same time, professions were defined in terms of existing social hierarchies, with economic and academic gatekeeping employed to only admit those at the top of class, race and gender hierarchies (Macdonald, 1995; Martimianakis et al., 2009). Those who were able to get into a profession secured even more power and capital; ironically, something they already held, given the gatekeeping

over entry to the professions (Marshall, 1995). Those who did not possess the appropriate capital in relation to social class were never afforded an opportunity to enter the professions in the first place (Adams, 2010; 2015).

Occupational therapy was granted professional status in the 1920's (Ontario Society of Occupational Therapists, 2020), and the profession has continually expanded over the years, with required educational credentials rising from a diploma to undergraduate degree, then a Master's degree (Cockburn 2001b, c; Green et al. 2001), and increasingly today a doctorate in the USA (American Occupational Therapy Association 2018). However, the occupational therapy profession is still engaged in working to set itself apart from other rehabilitation professions such as physiotherapy while also fighting for a seat at the table as a core health profession. Its development as a health care profession is hindered by the feminine composition of the workforce, but also by the fact that many referrals for service come through physicians, reducing professional autonomy. This is not to say that referrals outside of formal health care spaces (e.g., education, third party insurers) are not more flexible, but to highlight that occupational therapy as a health profession is at times hindered by formal health care institution processes.

Embodying 'professionalism' entails presenting the cultural capital (knowing the 'right' kinds of things) and ways of being that are expected, normalized within fields of practice established by and for members of elite social groups (Bourdieu, 1986). The ways of being and cultural capital presumed and expected within the professions are those of white, upper-class men (Jenkins, 2014; Vinson, 2019). Over time, these "taken

for granted assumptions about the requirements of professional life" (Vaidyanathan, 2015, pg. 161) are embodied into who that person is and what the profession represents, resulting in a person-professional identity merger (Rotert, 2006; Vaidyanathan, 2015). Such mergers are often less possible, or less successful, for occupants of professional roles who are not white, upper-class men.

Finally, the construction of the professions and their elite status within society are centered around power. Members of the health professions possess power through their (expert) knowledge, which grants them control over specific spheres of social life, and this relationship between power and knowledge provides elite social status to some groups while marginalizing others (Martimianakis et al., 2009). During the inception of the health professions, those who entered them were made up of individuals who already held significant capital within society through class, race, and gender, affording them significant knowledge and power; professional credentials in turn reinforced and protected the boundaries of 'insider' and 'outsider' status for the professions. This social closure, the reinforcing of social power through elite credentials, is intensified when entry into professional power occurs through post-secondary education. As noted above, such education is grounded in Euro-Western (colonial) worldviews.

Post-secondary institutions: A mirroring of Euro-Western values and epistemologies

For centuries, Euro-Western worldviews and their ontological, epistemological, and axiological underpinnings have formulated the 'dominant' worldview in Canada, with whiteness and white supremacy remaining uninterrogated and invisible within society (Moreton-Robinson, 2006). White supremacy relentlessly became the *status quo* norm

among all mainstream systems. The post-secondary education system therefore is grounded in and derived from Euro-Western (colonial) epistemologies, resulting in a need for Indigenous postsecondary students to walk a tight rope traversing between Western and Indigenous worldviews (Loppie, 2007).

Currently, post-secondary institutions are working to incorporate diverse ways of knowing, being, and doing; however, the underlying structure of these institutions remains a mirroring of Euro-Western (colonial) values and ideologies (Battiste, 2017). Much of the current efforts for change surround recruiting diverse students and incorporating diverse epistemologies and ways of knowing into courses – which are important and meaningful first-step changes. However, the foundations of these institutions are rarely questioned or modified, meaning the institution currently suits a particular 'kind' of learner, one that reflects the values and ideologies of the dominant Euro-Western society. This leads to considerable difficulty enacting real, meaningful change for students who are outside of the 'norms' of the typical student admission that governed these institutions for decades. Complex experiences arise for students who may not feel like they fit in and may not see themselves reflected in the institutional culture (Beagan, 2005/2007; Gallop & Bastien, 2016; Pidgeon, 2008).

Superficial change towards inclusion has sparked many inequities in post-secondary education for diverse peoples. Studies have shown that solid social relationships, and those who perceive a sense of belonging within their studies are positively rewarded through being more motivated and dedicated to their work and are more likely to meet their individual goals (Cemalcilar, 2010; Osterman, 2000). Therefore,

one can envision what the consequences are for not belonging, fitting in, or being able to foster secure relationships with others. Yet, this is the reality for many diverse students. This leads to inequities in educational attainment across different groups of people; for example – in the 2016 Census, both Black men and women were still less likely than the white population in Canada to hold a Bachelor's degree (Statistics Canada, 2020). These results are mirrored for educational attainment among First Nations, Inuit, and Métis Peoples in Canada (Statistics Canada, 2018). Therefore, not only are Indigenous Peoples coming into post-secondary institutions at a rate not comparable to the population in Canada generally, for those who do wish to obtain a post-secondary education, experiences are often challenging, resulting in issues of recruitment and retention, and overall lack of representation (Gore, 2017; Smith, McAlister, Gold, & Sullivan-Benz, 2011).

Indigenous experiences in post-secondary education

Given that post-secondary institutions are steeped in colonial ideologies and epistemologies, it is not surprising that very few Indigenous Peoples pursue post-secondary education in comparison to the rest of the population (Gallop & Bastien, 2016), though in recent decades this gap is closing. Indigenous students who enter the academy are often first in their family to do so (Gore, 2017), one of few Indigenous Peoples in their program (Smith et al., 2011), and they may experience alienation, discrimination, and racism within the Euro-Western education system (Currie et al., 2014; Battiste, 2017). Indigenous students are often subtly coerced into assimilating to the Euro-Western worldviews that guide the post-secondary education systems in Canada (Battiste, 2017). These experiences are situated within the context of a colonial past and

present that underpins virtually every aspect of post-secondary education within Canada, often making pursuing a post-secondary education a negative experience for Indigenous students (Battiste, 2017; Etowa et al., 2011; Slayter et al., 2016; Wilson et al., 2011). These experiences, along with the increase in Indigenous presence in the academy and activism by Indigenous students and scholars to better support Indigenous academic excellence, have resulted in calls for radical change to post-secondary education.

Post-secondary institutions, in response to these above-mentioned pressures, are currently in a state of flux. Many are in discussions surrounding equity, diversity, and inclusion in relation to Indigenous student success yet, Indigenous communities do not necessarily see themselves as part of the 'diverse' group as they were the original and First Peoples with all others arriving after as the diverse. There are currently calls to Indigenize or decolonize educational institutions, yet there are inherent problems with this agenda. As Gaudry and Lorenz (2018) outline, efforts within the academy can be categorized as Indigenous inclusion, reconciliation Indigenization, or decolonial Indigenization, helping to clarify where Canadian institutions are, and where they need to go. First, however, it is important to understand the definitions of both Indigenization and decolonization.

Indigenization and decolonization: What are they?

Indigenization and decolonization are used in varying ways by scholars, and different disciplines within the academy are at different stages regarding Indigenizing and decolonizing efforts. Theoretically, Indigenization encompasses the incorporation of Indigenous knowledge systems and values into the academy (Kuokkanen, 2008).

Indigenization is often described as a step before engaging in decolonization, but not always. Indigenization follows more or less the *add and stir* approach cautioned against by Battiste (2017), where Indigenous content is brought forward and mixed into already existing systems and curricula. In the literature, for example, Pidgeon (2019) and Styres (2019) explore Indigenization in the context of education and highlight risks related to Indigenizing the academy such as academic freedom to include or exclude Indigenous knowledge, settler resistance, along with issues of infusion, integration, and decontextualization. These concerns illustrate the difficulties of bringing together two distinct knowledge systems (Indigenous and Euro-Western) and the risk of decontextualizing Indigenous knowledge to meet colonial knowledge standards. In contrast, decolonization is defined as a long-term process of divesting colonial power and rule over policies, practices, structures and knowledges (Smith, 2012, see also Gaudry & Lorenz, 2018; Tuck & Yang, 2014). For post-secondary institutions, decolonization represents a removal of colonial power and underlying influences to instead foreground Indigenous Peoples, perspectives, and voices in the academy. Yet, at the same time, the term itself is contested, as it centers settler knowledge and colonization (Rico, 2013), which is exactly what the meaning of the term is trying to avoid. Tuck and Yang (2012) suggest decolonization is often used as a metaphor within the education context, rather than a set of actions or practices. They explain that we must delve deeper to truly understand and enact the centering and privileging of Indigenous knowledge, which must include acknowledgement of land, land appropriation, and land theft.

In their framework of Indigenous inclusion, reconciliation Indigenization, and decolonial Indigenization Gaudry and Lorenz (2018) note that because decolonization is deemed too radical a step for institutions at this time, Indigenization is often what is attempted, under the guise of decolonization language. While many authors understand the need to use Indigenization as a step towards decolonization (Gaudry & Lorenz, 2018; Pidgeon, 2019; Styres, 2019), George (2019) challenges this assumption by arguing that we must begin with decolonization efforts; otherwise, appropriate attention to and effort in interrogating structures and systems cannot take place. However, it is less clear how to implement such radical change in a colonial institution. Examples of decolonizing education (e.g. Batz, 2018; John, 2018; Simpson, 2014; Wildcat et al., 2014) demonstrate practices that are context and land specific, grounded in Indigenous knowledge systems and created by, and for, Indigenous Peoples – yet they virtually all occur outside of colonial institutions. They ignore colonial education systems entirely and are geographically-, time- and context-specific, leaving unanswered questions about how to enact decolonization in established post-secondary institutions, and whether that is even possible.

I focus here specifically on Indigenization and decolonization as they pertain to efforts in the academy. As such, decolonization will be framed as a pursuit to decenter colonial control and rule over education and knowledge, along with the policies and practices that guide education. In contrast, Indigenization will be framed as bringing Indigenous knowledge – ways of knowing, being, and doing – into the current structures of the academy. This literature, which is still relatively new in the academy, is largely

influenced by calls for self-determination and Indigenous sovereignty. These calls emphasize Indigenous control over policies and practices, including the development and centering of Indigenous knowledges in education systems.

Current efforts for change: A framework

Given the broad scope of literature on this topic, a framework to understand Indigenization and decolonization efforts is important. As mentioned above, the framework outlined by Gaudry and Lorenz (2018) helps us better understand Indigenous experiences in post-secondary education while framing efforts for change under discrete, yet continuous categories. This framework will be used to contextualize the work being done within the health professions broadly as well as the occupational therapy profession specifically to address calls for change within post-secondary health professional education. For Gaudry and Lorenz, Indigenous inclusion supports increasing Indigenous participation, and subsequent adaptation, into the current academy structure; reconciliation Indigenization includes the bringing together of Indigenous and Euro-Western knowledges to develop new understandings of knowledge and support further relationship-building between the academy and Indigenous communities; and decolonial Indigenization refers to a complete overhaul of the academy which balances power relations and transforms the academy into something dynamic and new, meeting the needs of all. This framework provides a clear way to categorize efforts and subsequently frame progress made. Gaudry and Lorenz (2018) understand it as a spectrum, where each of the three categories has specific characteristics but together, they also form a continuum.

Indigenous inclusion. Indigenous inclusion is described by Gaudry and Lorenz (2018) as an approach that includes increasing Indigenous participation in the education system. These activities include increasing seats available for Indigenous students, hiring more Indigenous faculty/teachers, adapting processes and curricula to better support their needs, and adding Indigenous content into already existing education systems, policies, and curricula. A hallmark feature of Indigenous inclusion is an increase in Indigenous presence within these systems in the absence of a critical examination of the already existing structures and systems that had led to Indigenous exclusion in the first place. This is the current common discourse for post-secondary education systems, as these efforts are easily initiated with minimal structural changes (Gaudry & Lorenz, 2018).

Indigenous inclusion is arguably the most prevalent approach within the academy. Overwhelmingly, institutions gear their efforts towards increasing enrollment and hiring more Indigenous faculty (Martin & Seguire, 2013; Rimmer, 2017; Slayter et al., 2016; Smith, et al., 2011; & Wilson et al., 2011). For example, in health professions education, most studies explore recruitment and retention of Indigenous students, with Martin and Sequire (2013) and Rimmer (2017) exploring these issues from a Canadian perspective, Slayter et al. (2016) from an Australian perspective and Wilson (2011) from the perspective of Aotearoa. Synthesizing many studies, Smith et al. (2011) determined that barriers such as low high school completion rates, students needing to leave their communities, social and cultural as well as financial needs, need to be addressed through a multi-level approach. Kovach et al. (2014) explored faculty perspectives (both

Indigenous and non-Indigenous, N=16) on the inclusion of Indigenous knowledges within the academy, with the key findings mirroring studies above identifying significant concerns with recruitment, retention, overburden, and mentorship and support gaps. Although these studies are important and provide insights into Indigenous student experiences, they do little to address the underlying reasons for inequities in Indigenous participation within the academy in the first place and focus on a reactive rather than proactive approach.

Some efforts are not as easily categorized as solely Indigenous inclusion. Some studies go beyond surface level inclusion initiatives such as recruitment and retention in ways that focus on the balance of Indigenous and Euro-Western knowledges and building relationships with Indigenous Peoples and communities for guidance. For example, Martin and Sequire (2013) provide an alternate pathway through nursing that focuses on and foregrounds Indigenous curricula and establishes a cohort of Indigenous students. Pjil-Zeber and Hagen (2011) and Delapp, Hautman and Anderson (2008) advocate for culturally relevant content and increased partnerships and connections with Indigenous communities to address barriers for Indigenous nursing students. These initiatives approach reconciliation Indigenization, the second category in Gaudry and Lorenz's (2018) framework, as there is a concerted effort to forefront and bring together Indigenous knowledges alongside an increase in collaboration and guidance from Indigenous communities themselves to address barriers. However, despite an increased focus on partnerships, these studies do little to challenge existing structures, settler

colonialism, or white supremacy present in education systems, which are key features of decolonization.

Reconciliation Indigenization. Reconciliation Indigenization has "rhetorically been adopted by Canadian institutions" (Gaudry & Lorenz, 2018), yet the efforts outlined above largely do not meet the requirements. Reconciliation Indigenization requires a more critical stance on education, challenging Euro-Western ideologies, assumptions, and values, seeing the value of and foregrounding Indigenous knowledges, and creating partnerships and collaborations to address the inequities Indigenous students experience within the education system. This means that to be reconciliation Indigenization, efforts need to move beyond *acknowledging* and/or *including* Indigenous knowledges to *valuing* and *seeking* those knowledges through equal partnerships, while also recognizing Euro-Western knowledge domination and its assumptions and biases within the academy. A few examples above provided some features of reconciliation Indigenization; however, most reconciliation initiatives take a more critical approach to addressing the lack of Indigenous representation and the culturally irrelevant curricula in the academy.

Efforts at this level from post-secondary institutions mainly focus on anti-racist and transgressive efforts. Transgressive education is defined as teaching that nurtures reflectivity and critical thinking surrounding social conditions (Florence, 1998). Outside of the health professional education context, Iseke-Barnes (2008) provides two teaching scenarios which include activities she terms 'decolonizing' geared towards allowing students to understand interlocking systems of oppression, as well as the social construction of inequalities. In the context of health professional education, Rodney

(2016) echoes this sentiment as she reflects on her experiences teaching nursing in the Global South, noting that recognizing and understanding colonization are major first steps towards decolonizing. Through their realist review of implementing anti-racist pedagogy in health professional education, Diffey and Mignone (2017) highlight that the success of utilizing anti-racist pedagogy in this context relies on numerous complex factors such as institutional readiness and instructor engagement. In reconciliation efforts, recognizing colonialism constitutes a first step to decolonization (Battiste, 2017). While these examples fit into the category of reconciliation Indigenization, given their focus on furthering understandings of Indigenous knowledge and its relationship to Euro-Western knowledge colonizing the academy, they are arguably also connected to Indigenization inclusion (Gaudry & Lorenz, 2018), given the lack of effort to create new, meaningful understandings of knowledge and approaches to post-secondary education. These examples are far from exemplifying decolonization as defined in education (Smith, 2012; Tuck & Yang, 2014).

Clearly an important feature of reconciliation Indigenization is the colonial underpinnings of the academy itself, with its innate challenges for Indigenous students. The literature in this area tends to focus on the colonial nature of post-secondary institutions broadly (rather than examining it within health professional education specifically), however, it links directly to the health professions given the shared colonial underpinnings. Marker (2014) explored the reproduction of colonial dominance and subsequent inequality within the academy, noting that First Nations graduate students experience unique tensions compared to settler students as they pursue an education

such as a commitment to community and in some cases navigating the English language as well as Western ideologies. This may leave students needing to create or recreate words to fit with Indigenous ways of knowing and operating back and forth between two worldviews. He sheds light on the colonial patterns of knowledge production within the academy, with the lack of discussion surrounding these colonial underpinnings making it difficult to enact any real change.

Schick and St. Denis (2003) do similar work, focusing on ideological assumptions about the production of inequality through liberal colonial beliefs: race does not matter, everyone has equal opportunity, and individual acts of good intentions secure innocence and superiority. They note that teaching students to reflect on their own positions and identities can support enacting anti-racist educational practices. Andreotti et al. (2011) explore epistemological pluralism within the academy, outlining the ethical and pedagogical challenges of bringing in Indigenous epistemologies and translating them to fit into a Euro-Western system. They discuss the need for Indigenous and Euro-Western epistemologies to 'meet in the middle,' which – in the spirit of reconciliation – requires a substantial shift from colonial post-secondary institutions. Scholarship on reconciliation approaches provides strong theory, but is typically scant on implementation, such as how to address epistemic blindness (a lack of acknowledgement/appreciation for epistemologies other than one's own) if it is intertwined with domination; how reflections on social positioning influence overall systems; how to alter power dynamics present in the academy; and how to bring Indigenous epistemologies onto equal footing

after years of discrimination and discreditation by settlers and institutions. It will be very hard to bring this theory into practice.

To bring reconciliation Indigenization into practice demands the fostering of relationships between the academy and Indigenous communities. Again, although the literature focuses on post-secondary education partnerships broadly given the lack of health profession-specific literature, this applies broadly to areas of inquiry for health professional education programs to better support Indigenous knowledges in health. Ball (2004) presents an example of a partnership between the University of Victoria and five Cree and four Dene First Nations communities in Central Canada. This partnership included the collaborative development of a community-based delivery of a university accredited program in child and youth health, similar to what is offered in the University of Saskatchewan's Indian Teacher Education Program (University of Saskatchewan, n.d). Such partnerships are emerging more and more; for example, the [now terminated] Integrative Science Program at Cape Breton University (Iwama, Marshall, Marshall & Bartlett, 2009). They demonstrate potential for meaningful engagement of Indigenous Peoples and communities alongside post-secondary institutions and illustrate the relationship-building criteria inherent for reconciliation Indigenization. Nonetheless, these partnerships still answer to colonial rule and are working under the guise of a colonial institution, for now. This means that although these partnerships are bringing more Indigenous knowledge into the academy and arguably changing some of the way things are done, Indigenous communities are still required to play by colonial institutional rules such as honorariums and required bureaucratic processes, and these programs can

be terminated at the whim of the institution. Only when Indigenous Peoples and communities hold decision-making power will we be closer to decolonized education.

Decolonial Indigenization. Decolonial Indigenization is described by Gaudry and Lorenz (2018) as a complete overhaul of the current education system into something dynamic and new. In conceptualizing this through the definition of decolonization from Smith (2012), which she notes requires a divesting of colonial power in virtually every way – through policies, procedures, and knowledges – the goal of decolonizing both general and post-secondary education has not been met. Although many authors refer to their efforts as decolonizing (see, for example, Iseke-Barnes, 2008; and Newberry & Trujillo, 2018), they do not meet the requirements based on definitions provided, instead typically adopting a reconciliation Indigenization stance. Those approaches indicate important transformative steps forward but do not result in a dynamically new system. This finding is in line with what Tuck and Yang (2012) observed in the academy, where the term decolonization is used more as a metaphor as opposed to engaging in work that meets the true definition of the term. As such, none of the literature reviewed presents clear practical examples of decolonizing the current education system. It is for this reason that efforts within the academy are still falling short and leaving a slew of negative experiences for Indigenous students.

Therefore, utilizing this framework has value particularly in relation to ideas generated by Indigenous OTs relating to current efforts underway within post-secondary institutions. This framework Gaudry and Lorenz (2018) was presented to all Indigenous OT participants, in our discussions about changes occurring and changes needed within

the profession. For example, for an initiative or effort to be categorized as decolonial Indigenization, it would need to describe at minimum a significant overhaul of the current system into something dynamic and new. Such initiatives and efforts would be categorized as radical change, divesting colonial power in numerous ways.

Indigenous experiences in the health professions

Calls for radical change, particularly around movements toward Indigenization and decolonization, pervade the health professions. The health professions are arguably moving slower than other post-secondary programs in relation to recruiting and retaining Indigenous Peoples, with 1-2% of the health workforce identifying as Indigenous (National Aboriginal Health Organization [NAHO], 2006; Statistics Canada, 2016a). This is compounded by the *context* of the health professions, which (as argued above) have been and continue to be exclusive, elite careers, typically reserved for upper-middle class, white people (Macdonald, 1995; Jenkins et al., 2021). This has resulted in rigid norms and rules surrounding who and what constitutes a health professional (Martimianakis, Maniate, & Hodges, 2009), which can have an impact on the health knowledge that is available within the professions due to employing a particular '*kind*' of professional. This also can contribute to a health care system that continues to privilege and value Euro-Western ways of knowing, in turn privileging Euro-Western professionals and patients.

The ramifications of this are well-documented, with steep inequities in care for Indigenous Peoples accessing health services (Allan & Smylie, 2015; Horrill et al., 2018; Pilarinos et al., 2023), as well as harmful experiences for those who enter health

professions education programs (Simpson, 2022). Indigenous students have described feeling discriminated against, lonely, and lacking support (Etowa, Jesty & Bukic, 2011; Foxall, 2013), experiencing cultural discontinuity (Pjil-Zieber & Hagen, 2011), and a constant need to resist racism (DeCoteau et al., 2017; West et al., 2016). Researchers have found that Indigenous students require supports like free tutoring, reduced class sizes, and course loads, a focus on Indigenous knowledge within the curricula, continuity of instructors and a focus on community-based partnerships (Delapp et al., 2008; Martin & Seguire, 2013). The retention of Indigenous health professions is hindered by complexities such as desiring to be close to community, financial barriers, cultural discontinuity, and a lack of supports in post-secondary programs specifically for Indigenous students (Rimmer, 2017; Slayer et al., 2016; Smith et al., 2011; Wilson et al., 2011). When Indigenous students entering health professional programs feel insufficiently welcome to stay, this may contribute to the inequities seen within our health care systems vis-à-vis the racism Indigenous Peoples often experience access health care (Allan & Smylie, 2015; Browne et al., 2011; Pilarinos et al., 2023) which can lead to delays in accessing and receiving care. Thus, there is a dire need for more Indigenous Peoples entering into health care professional education, as well as more supports for those striving to resist professional assimilation once there.

Indigenous occupational therapists, specifically, have noted feelings of loneliness and lack of belonging in the profession that begin in professional education programs (Reid & Pride, 2023; Valavaara, 2012; White et al., 2021). Occupational therapy is still grappling with the colonial nature of the profession and the need to decentre whiteness

(Gibson, 2020). Nonetheless, the historically rigid, unwelcoming culture of the health professions leaves Indigenous Peoples in a struggle to improve health care while fiercely fighting colonial systems resistant to change. It is largely due to these factors that the health professions have been asked through the TRC (2015) and the Missing and Murdered Indigenous Women, Girls, and Two-Spirit people inquiry (MMIWG2S, 2019) to recruit, retain, and create welcoming spaces for Indigenous Peoples working in and seeking health care.

Truth and Reconciliation Commission and MMIWG2S

The TRC was created to support the Indian Residential School Settlement Agreement, providing much needed clarity, compensation, support, and actionable steps towards reconciliation with Indigenous Peoples. Spanning over 6 years, the Commission "intended to lay the foundation for the important question of reconciliation" (TRC, 2015b, pg. VI), issuing 94 calls to action spanning across vast areas such as child welfare, language and culture, health, justice, and education. There are 11 calls to action that pertain to education, such as: repealing section 43 of the criminal code (the 'spanking law'), better funding reporting requirements imposed for governments, and full participation and informed consent of Indigenous Peoples and communities in education decisions. Further, the TRC provides a call to action regarding eliminating the education gap between Indigenous and non-Indigenous peoples, which spans from improvements in early childhood education programming to more reliable funding support and culturally appropriate curricula for Indigenous post-secondary students. With education described as a foundational proximal determinant of health (Reading & Wien, 2009), the

Honourable Justice Murray Sinclair noted that, “education got us into this mess, and education will get us out of it” (Watters, 2015). Education is also a way to begin addressing numerous other calls to action.

Since the release of its final report in 2015, progress on the TRC calls to action has been slow (Monkman, 2020; Ritchot, 2020). Around the same time that the TRC final report was emerging, the National Inquiry into MMIWG2S people was just beginning. This inquiry, organized to address the staggering rates of violence, disappearances, and murders against these Indigenous groups, aimed to also bring awareness and action to the high rates of poverty, housing, food insecurity, unemployment, and educational inequity experienced by Indigenous women, girls, and 2SLGBTQQIA+ people, and how those inequitable structures feed into high rates of violence. These conditions are a direct result of colonialism, making an important link between colonial rule, the social determinants of health, and violence. The Inquiry’s final report, published in 2019, generated 231 Calls to Justice. It shares similarities to the TRC report in that it recognizes the resistance to change and desire to maintain the *status quo* by institutions and governments (MMIWQ2S, 2019), bringing to light the complexity of addressing and reconciling the needs of Indigenous Peoples. Both of these reports, although broad in scope to help address the numerous inequities experienced by Indigenous Peoples, provide detailed guidance on the educational needs of Indigenous Peoples to eliminate gaps between Indigenous and non-Indigenous peoples.

It has been eight years since the TRC report, and four since the MMIWG2S report. However, these calls from Indigenous Peoples, communities, and organizations for

radical change to the mainstream education system broadly, and health professional education specifically, are not new. The profession in Canada has declared commitment to improving Indigenous health and supporting reconciliation and decolonization efforts (e.g., ACOTRO, 2022; CAOT, 2016a/2018a), as well as a pointed commitment from CAOT to addressing the TRC Calls to Action through the creation of a TRC Task Force (CAOT, 2016a). Occupational therapists have been stressing the importance of taking meaningful action on these recommendations (Restall et al., 2016), yet the history of the profession and the way it is structured within colonial post-secondary institutions make it rigid and resistant to needed, meaningful change.

History of occupational therapy in Canada

Since its inception around the time of the First World War, occupational therapy has been a profession founded on and mirroring Euro-Western epistemologies and values, resulting in instances of friction for those who come from diverse backgrounds and worldviews (Gibson, 2020; White & Beagan, 2021). During the First World War, the occupational therapy profession emerged to support soldiers. Therapists during this time would support wounded or disabled soldiers with vocational training to facilitate a smooth transition back into their everyday lives post-war (CAOT, 2016b). Post-war, therapists were moved into different spaces – with many of them going into tuberculosis sanatoriums and mental health facilities, while also supporting community health through workshops (PEIOT Society, n.d). Not long after the war, the Canadian Association of Occupational Therapists (CAOT) was founded in 1926 (CAOT, 2016b), with the first official university occupational therapy program emerging in the same year at the

University of Toronto (Friedland, Robinson & Cardwell, 2000). Throughout the 1930's and 40's, occupational therapists were still heavily involved in work and work rehabilitation – supporting newly discharged patients from hospital in their return-to-work process (Cockburn, 2001a).

Over time, OTs began working in more diverse areas such as paediatrics and psychiatry (PEIOT Society, n.d). This continued well into the 1960's, as therapists supported soldiers post World War II, and moved into orthopaedics, neurology, and psychiatry (Cockburn, 2001b). The profession expanded significantly between 1950 and 1970 – with many universities across Canada creating their own occupational therapy programs (PEIOT Society, n.d; Cockburn, 2001b). The profession began to work towards the goal of self-regulation, and combined training with Physical Therapists ended in the 1970s, making occupational therapy a stand-alone baccalaureate degree (PEIOT Society, n.d). Many of the core guidelines and practice frameworks emerged in the 1980's (e.g., intervention guidelines for client-centred practice), and although extensive modifications have happened since then, many of the core values from the early days of the profession remain relevant (Trentham, 2001; Townsend & Polatajko, 2013).

In Canada, the profession began to move entry to practice programs towards a Master's program in the late 1980's, however, many universities across Canada resisted these changes for as long as possible. The first university to begin making this shift was the University of Alberta, who did so in 1986 (Trentham, 2001), however, many universities including the University of Alberta, for example, were still accepting bachelor level intakes into the early 2000's. Currently the overwhelming majority of Canadian

programs are at the Master's level, and programs in the U.S. are increasingly moving to the doctoral level. From the 1990's until today, the profession has moved into diverse places and spaces such as long-term care, ergonomics, and seating, to name a few. An emphasis on evidence-based practice as well as technological advancements have allowed the profession to continue developing over numerous decades into what occupational therapy is today – a profession that supports getting people back to doing any occupations, activities they want or need to do.

Occupational therapy: A unique health profession

In the late 1980's, the profession of occupational therapy shifted its focus from the traditional medical model used in other health professions towards a framework of client-centered enablement, community-based practice and health promotion (PEIOT Society, n.d), making it a unique health profession. The core values include concepts of equality, respect, and justice with a strong emphasis on client-centred practice and client-centred enablement (CAOT, 2018b).

The profession has been described as a holistic profession entrenched in the biopsychosocial model (Gentry et al., 2018); the Canadian Association of Occupational Therapists describes the profession as being structured around 3 central occupations: self-care, productivity, and leisure (CAOT, 2016c). However, the profession is much more than these narrow categorizations in clinical practice – and current literature points to the profession moving away from structured occupational 'categories' (Hammell, 2009/2023) towards a more nuanced and complex understanding of the occupations that people need or want to do in their everyday lives. This is most evident in the new

textbook by Egan & Restall (2023) illuminating relationship-focused occupational therapy. Occupational therapists work in a vast array of practice areas from community, within institutions or government, as well as within industries, corporations, and insurance companies (CAOT, 2016c). The range of practice is continually expanding as the profession evolves. Therefore, occupational therapy is conceptualized as a unique health profession in that it has developed virtually every aspect of its role around notions of client enablement and client-centered practice. This situates the profession slightly differently compared to nursing or medicine, who also emphasize client-centered practice but are situated closer to a biomedical model compared to occupational therapy. Models that guide practice in Canada for the last 20 or so years have overwhelmingly emphasizes spirituality at the center of the human person, promoting attention to holistic well-being and the impacts of the environment on the health and wellbeing of the client (Townsend & Polatajko, 2013), meaning the profession has resonance in holistic biopsychosocial perspectives. In theory (if not always in practice) the client maybe an individual or a collective.

The above-mentioned features of occupational therapy are well aligned with many Indigenous perspectives. Even though the occupational therapy profession has its roots and origins in a non-Indigenous perspective, it is a unique health profession particularly in its attention to and emphasis on family and community in the health and wellbeing of individual clients, its holistic view of the individual and their daily activities and needs, and the centering of spirituality alongside physical and mental health in social context. The profession is inherently flexible as its situated in the occupations that people

need and want to do – resulting in a profession that is heavily reliant on the unique experiences and challenges of diverse peoples in the context in which they live. Key features of Indigenous knowledges include its emphasis on place and context (Cajete, 1993), a focus on relationality and reciprocity (Wilson, 2001; Chilisia, 2019), and holism (Antoine et al., 2018) and within occupational therapy, there is potential to build on the challenging of the biomedical model and the decontextualized view of health, something the profession is already doing, to move towards a greater understanding of need and value for Indigenous epistemologies within the profession.

The flexibility of the profession, its continually expanding practice areas, its emphasis on holistic approaches, and its attention to spirituality and environments all mean occupational therapy has considerable potential for positive connections with Indigenous Peoples. However, similar to other structured and formally regulated health professions, the profession has been described as being steeped in colonial views and white supremacy (see, for example: Bauer et al., 2023; Emery-Wittington, 2021; Grenier, 2020; Hammell, 2019; Hunter & Pride, 2021; Price & Pride, 2023; Reid & Pride, 2023; White & Beagan, 2021)

Occupational therapy: A colonial, Euro-Western profession

Within the past decade, the profession and those working within it have begun to document its colonial roots and the implications for meeting equity, diversity, and inclusion mandates that the profession has brought forward – as well as the implications for direct clinical practice with diverse clients. For example, a recent paper by Sterman, Njelesani and Carr (2022) discusses the need for the OT profession to move beyond

diversity and inclusion towards anti-racism. They also highlight that how we do this, and what tools we draw from, are relatively unclear and uninterrogated in the profession. This is further supported in a paper published by Lerner and Kim (2022) where they discuss the need to develop an anti-racist practice in occupational therapy via developing much needed guidelines, as well as Ahmed-Landeryou and Emery-Whittington (2022) who capture discussions of co-creating an anti-racist framework in occupational therapy. Notably, anti-racism is emerging as a necessity to embed throughout the occupational therapy profession. Drawing specifically on Indigenous knowledges, a paper by Niki Kiepek (2023) attempts to push the occupational therapy profession beyond its colonial underpinnings to consider ethical relationality and interspecies occupational engagement. This paper allows us to consider different ways that the occupational therapy profession might move beyond Western conceptualizations and advance reconciliation.

The profession of occupational therapy is steeped in a Euro-Western worldview (Beagan et al., 2022b/c; Grenier, 2020; Hunter & Pride, 2021; Jacek et al., 2023; Price & Pride, 2023; Trentham et al., 2007), and is noted to perpetuate colonialism through its admissions processes, theories, assessments, interventions, and outcomes that are entirely derived from a Euro-Western worldview (Maclachlan, Phenix, & Valavaara, 2019; Hammell, 2019) designed to serve Euro-Western clients. Further work by Beagan et al., (2022a) illuminates epistemic racism experienced by occupational therapists from marginalized groups, pointing out that not only is the profession designed to serve Euro-Western clients, but it also discriminates against racialized and non-Western therapists

entering the profession as well. A study by Razek et al., (2022) from McGill University highlights the need for a Black Student Pathway into occupational therapy, which has been implemented elsewhere in Canada for marginalized groups, albeit outside of occupational therapy (e.g., Dalhousie University's Medical Program, which has an Indigenous specific pathway). Importantly, the profession of occupational therapy should be considering ways to better support diverse applicants, given its colonial roots.

In one of the key works critiquing the profession to date, Grenier (2020) describes how white supremacy is permeated throughout the entire profession and highlights the need to move past a cultural competency framework towards more critical interrogation of the underlying values and impositions of the profession. This work is echoed by Gibson (2020) and Emery-Wittington (2021) who call for decentering whiteness within the core of the profession to make impactful and long-lasting change within the profession, as well as Kiepek (2023), who describes the need to begin honouring Indigenous worldviews within occupational therapy.

More specifically, therapists have been doing the work of bringing these uninterrogated and invisible roots of the profession to light. From her years of work with Indigenous communities, Gerlach (2018a) questions the perceived notion that occupational performance and engagement is always safe and neutral. Hunter and Pride (2021) note that, "the narrow way self-care, productivity and leisure structure the profession; the use of child-development milestones based on Eurocentric expectations; the importance of time- and goal-orientation; the emphasis on Eurocentric values and experiences in assessments; the emphasis on objectifying and scoring performance in

assessments" (pg. 331) are just some problematic aspects of the profession in the context of the ever-growing diverse population it serves. They provide a concrete example of how the Canadian Model of Client-Centred Enablement (CMCE) is steeped in hierarchical power relationships and paternalist control by critiquing its Euro-Western origins.

Another newly published paper by Price and Pride (2023) follows a similar method of critiquing the Canadian Occupational Performance Measure (COPM) and describe its Eurocentric approach rooted in colonialism, power dynamics, and the importance of cultural awareness when using assessments within Indigenous contexts. Nonetheless, the key message highlights the need to think critically as occupational therapists: "As an assessment tool for use in Indigenous contexts, the COPM has potential, given its semi-structured nature and client-led approach. The benefits of this approach, however, can only be realized with proper training and culturally safer practices on the part of the therapist" (Price & Pride, 2023, pg. 8).

Some of these findings are similar to what MacLachlan, Phenix, and Valavaara presented at the 2019 annual CAOT Conference, as well as what Bauer et al. (2023) found in their most recent scoping review on Indigenous Peoples and occupational therapy in Canada. Expanding on my own previously published integrative review (White & Beagan, 2021), Bauer and colleagues' scoping review points to a need to recognize colonial history, undertake personal and professional reflection, identify Western ideologies operating, engage in partnerships, and recognize social and systemic barriers as key ways forward, while also emphasizing the need for Indigenous led research and

curricula transformations. As well, Jacek et al. (2023) recently published a study exploring knowledge gaps regarding occupational therapists' knowledge gaps related to Indigenous People's health. Using a Delphi process they identified gaps in knowledge of colonialism, respecting knowledge, and power imbalances; Indigenous relationships, cultural safety, underlying assumptions of the profession and inappropriate use/imposition of Western norms; and the need to practice reflexively and critically, advocate and innovate, while ensuring awareness that occupational therapy has been and continues to be a vessel that perpetuates colonialism. These are all important contributions to the occupational therapy profession by beginning to identify ways forward to better serve the needs of Indigenous Peoples and communities in Canada. Yet, we are still grappling with how to best do these things while working within a colonially derived and grounded profession.

From literature emerging in the United States, a recent doctoral research project by Casimir (2023) explored the development of an occupational therapy program in a rural reservation community setting among the Navajo. This project aimed to move away from the standard conceptualizations of the profession toward developing something culturally-based and culturally-relevant for that population (e.g., Indigenous led) through building positive relationships with Navajo community members, demonstrating respect for their cultural values, and ensuring active collaboration among stakeholders. The notion of Indigenous-led is heavily emphasized by Reichert et al. (2023) in their recent paper detailing a community-driven needs assessment for rehabilitation services with Indigenous communities in Saskatchewan, Canada. Through this work, they were able to

identify locally relevant recommendations which will ideally improve access to rehabilitation services, including occupational therapy. Such newly emerging work will ideally provide the occupational therapy profession with needed information as well to support our ability to better serve Indigenous Peoples and communities.

Although it is well documented that there is a dire need for the profession to move away from focusing solely on Euro-Western values, assumptions, and ideologies towards a more critical and innovative profession that values and includes diverse perspectives and experiences, how to do this is less clear. The emerging work synthesized above is timely and needed, as the OT profession in Canada boasts a commitment to diversity, equity, and inclusion (EDI) (CAOT, 2016d) and has various practice networks and position statements dedicated to focuses like Indigenous health and newcomer experiences (see, for example: CAOT position statement on occupational therapy for Indigenous Peoples, CAOT, 2018a), yet change is typically focused on surface level issues such as recruitment and retention within the profession or creating extra resources to better support diverse needs. Although these are important efforts, they do little to change the underlying issues and roots of the profession itself, which may prove challenging for Indigenous therapists as well as clients and communities. To date there has been no research exploring therapist experiences in Canada.

Indigenous experiences in occupational therapy

The occupational therapy profession has been described as perpetuating systemic racism in its roots and in contemporary practices (Beagan, et al., 2023; Beagan, Sibbald, Bizzeth, et al., 2022; see also Beagan & CHacala, 2012; Bogg et al., 2006), as has

previously been illustrated in medicine, nursing and physiotherapy (e.g., DeCoteau et al., 2017; Etowa, Jesty & Bukic, 2011; Foxall, 2013; Hughes et al., 2021; Smith et al., 2011; Vazir et al., 2019). There is minimal research exploring the experiences of Indigenous occupational therapists in Canada. Simpson (2022) explored Indigenous student journeys through allied health programs (including occupational therapy) in the US, emphasizing the need for cultural safety, Indigenous student support units, and outreach. From Australia, Chontel Gibson (2020), a Kimilaroi occupational therapist, highlights the need for the profession to critically reflect on the ways Western infrastructures and systems dictate occupations within society and asks that we support decolonization efforts as Indigenous Peoples that not only resist oppressive Western ideologies but actively challenge them through their own cultural identities and occupations. She further links these efforts to the importance of Indigenous self-determination and ensuring human rights are central to the profession (Gibson et al., 2015). In a related paper she highlights the need to decolonize through a strengths-based framework to challenge the stereotypes and purposeful exclusion of Indigenous Peoples and actively resist colonization (Ryall et al., 2021).

From Aotearoa (New Zealand), Hopkirk and Wilson (2014) surveyed 18 therapists (7 were Māori) and then interviewed 5 experts (4 were Māori) exploring whether cultural perspectives influence OT practice. They created a framework for practice grounded in Māori ways of knowing, and similar to Gibson et al. (2015), they link this framework and efforts to center Māori epistemologies to Indigenous self-determination for health and wellbeing. These findings are echoed in the Aotearoa context by Isla Emery-Whittington

and Ben Te Maro (2018) and Emery-Whittington's more recent (2021) paper, critiquing the colonial theorizing of the profession in Aotearoa and highlighting the need to examine colonialism in the profession. In her 2018 keynote address Emery-Whittington shares her experiences of walking between two worlds yet feeling as though she belongs in neither as a Māori OT working in a colonial profession. Finally, Emery-Whittington (2021) notes the need to utilize Indigenous justice frameworks and Indigenous epistemologies to move towards decolonization.

Lastly, a recent study out of Aotearoa (Davis & Came, 2022) aimed to explore institutional barriers faced by Māori occupational therapy students, and found that cultural dissonance, cultural (in)competency, and the limitations of Western care were major barriers. Importantly, this work is drawing on firsthand experiences of Māori occupational therapy students, which is lacking not only in the Aotearoa context but across the globe in relation to firsthand Indigenous accounts, and illuminates the racism embedded within Western systems.

Given the literature emerging around the world, as well as the emerging critique of the Canadian occupational therapy profession being grounded in Euro-Western and white supremacy values, it seems likely that many Indigenous occupational therapists in Canada may experience significant discrimination and alienation working within a profession that may be ill-fitting for the unique Indigenous worldviews they bring with them. A presentation titled "*Beyond diversity: The need for an Indigenous occupational therapy community*" given by myself and other Indigenous OTs across Canada at the 2021 CAOT Conference (White et al., 2021), as well as a first-narrative experience of

isolation within the profession written by Kaarina Valavaara (2012), highlight the need for changes within the profession to support Indigenous students and clinicians. Similarly, Reid and Pride (2023) detail the extra work needed to create a sense of belonging for Indigenous occupational therapy students, and Clyne (2023) presents her experiences in occupational therapy school as well as ways forward for the occupational therapy profession. Given CAOT has committed to the Calls to Action outlined by the Truth and Reconciliation Commission of Canada (TRC, 2015b), the evidence beginning to accumulate in Canada and beyond suggests the profession has significant work to do to move towards reconciliation with Indigenous Peoples as clients and providers in the profession.

Occupational therapy: A promising profession

Despite negative experiences within OT, informal conversations among Indigenous OTs in Canada point to promise within the profession. Many Indigenous OTs have spoken at length during Indigenous OT network meetings as well as at conferences (White et al., 2021) about what drew them to the profession in the first place, which includes the deliberate challenging of the biomedical model, the emphasis on gaining a holistic understanding of the client, client-centered practice, and the centering of spirituality alongside physical and mental health in social context. It is important to note that to obtain an OT degree, one must be involved in the post-secondary education system for at minimum 6 years on top of the public schooling students would have received (likely also grounded in Euro-Western/colonial epistemologies and pedagogies). Therefore, Indigenous OTs are likely competent engaging in their everyday lives through

Euro-Western systems. Literature points to the ways in which Indigenous OTs may do this, taking core aspects of the profession, despite Euro-Western underpinnings, and utilizing and adapting them in ways that meet the needs of themselves and the communities in which they are working (Hunter & Pride, 2021).

Despite being grounded in and derived from a Euro-Western worldview, therapists are afforded considerable flexibility depending on area of practice as well as region (e.g., MacLachlan, 2010 for example of working in Northern Inuit communities), and this flexibility and ever-changing roles could be advantageous in making significant and lasting changes in the profession to better support Indigenous clinicians. For example, occupational therapy is continually expanding into areas of mental health, and as the years go on, OTs are being called upon to participate in, and fill gaps within, numerous areas relating to health and wellbeing. Further, the values espoused by occupational therapy profession and its goals align with Indigenous ways of knowing. For example: principles of caring for kin, encouraging engagement in daily activities that are grounded in the context and experiences of the client, and the ability to move away from a biomedical model towards considering key aspects of the social and physical environments to better support clients. As such, Indigenous OTs are often utilizing these aspects alongside our own cultural knowledge and ways of knowing, being and doing to better support clients.

Drawing on concepts grounded within Indigenous knowledge, such as Etuaptmumk, which is a guiding principle showing deep appreciation for the gifts of multiple perspectives (Bartlett, Marshall, & Marshall, 2012) may prove particularly

relevant and significant to the work needed within the profession. Being able to use or 'see' two (or more) different worldviews and utilizing them for the betterment of society (Bartlett, Marshall & Marshall, 2012) is relevant in a profession such as occupational therapy. Given its flexibility, OT has the potential to learn from Indigenous clinicians and leaders the value of Indigenous knowledge and concepts, beginning to rebuild the profession outside of a singular, Euro-Western worldview. The Gaudry and Lorenz (2018) framework outlined above can provide guidance and documentation on the work being done to date within the profession as well as where we need to go to move past basic Indigenous inclusion and towards decolonizing the occupational therapy profession. Calls for these changes are echoed within occupational therapy's university accreditation standards which ask that conceptual frameworks engage with concepts of inclusivity and diversity (CAOT, 2019) as well as engaging with anti-oppression, anti-racism, culture, equity, and justice (CAOT, 2012, pg. 13).

The profession of occupational therapy is a promising one for reconciliation given its flexible nature, focus on holism and client-centered practice, and its deliberate challenging of the biomedical model. However, the profession is grounded in and derived from a Euro-Western worldview, meaning that one needs to consider how this worldview impacts the work being done with Indigenous Peoples for reconciliation. This study contributes needed evidence to understand Indigenous OT experiences in the profession.

CHAPTER 3: METHODOLOGY AND METHODS

Theoretical orientation

Indigenous worldviews: Towards a decolonizing agenda

Indigenous worldviews, meaning Indigenous ontological, epistemological, and axiological underpinnings, are at times in contrast to Western (colonial) worldviews. These underlying philosophical assumptions impact the ways particular groups of people go about, see, and experience the world around them. **Ontology**, which is described as how one understands the nature of reality and its characteristics, asks the question of 'what is real?' (Creswell & Poth, 2018; Wilson, 2008). **Epistemology** is concerned with knowledge and what counts as knowledge (Creswell & Poth, 2018), getting at the nature of thinking or knowing (Chilisa, 2019). Finally, **axiology** explores value systems (Creswell & Poth, 2018), "the ethics and morals that guide the search for knowledge" (Wilson, 2008, pg. 34). Together, these underpinnings form what I will refer to as Indigenous worldviews.

Differences in philosophical assumptions between Indigenous and dominant Euro-Western worldviews are apparent. For instance, differing ontological beliefs can be seen between Indigenous and Euro-Western societies, with Indigenous worldviews grounded in a deep connection to spirituality, cosmovisions, and the idea of all things being interconnected (Hart, 2010; Wilson, 2008) whereas dominant Euro-Western worldviews are largely grounded in notions of individualism, linearity, and meritocracy, viewing things through a compartmentalized lens (Graveline, 2000; Kirkness & Bardnhart, 1991). Indigenous epistemologies differ in standards of proof and how we pursue notions

of “proof” and “truth” (Hickey, 2020) compared to mainstream Euro-Western knowledge. For example, Hickey (2020) outlines how Elders pass down knowledge given to them from their ancestors with this knowledge accepted as valid, truthful, and holding a high standard within Indigenous cultures, whereas for decades, mainstream Euro-Western knowledge delineated ‘proof’ and ‘truth’ through science and experimentation rather than the passing on of knowledge through generations. Axiology is impacted by the set of ontological and epistemological underpinnings of a particular group (Wilson, 2008), and as such, the ethical and moral guidelines that guide the search for knowledge also differ between Indigenous and Euro-Western populations. Neither is superior – however, the morals and ethics that guide Indigenous knowledge are distinct principles that are inherently different than Euro-Western and are at times incommensurable. It is these differences in ways of knowing between Indigenous and dominant Euro-Western worldviews, and the assumption of Eurocentric approaches as superior to Indigenous ways of knowing, that has underpinned and justified deliberate acts of genocide, assimilation, and cultural imperialism on behalf of settlers. This has left Indigenous Peoples and their knowledge systems relegated to a position of ‘lesser than’ and excluded from society.

Indigenous Peoples and our worldviews have been relegated to the periphery through the superiority of Euro-Western science that shaped the research enterprise. This was done through practices of colonial research (Battiste, 2017; Smith, 2018) which continually dismissed and ignored Indigenous ways of knowing, or appropriated Indigenous knowledges by subsuming them into Euro-Western science as its own

discoveries – rarely, if ever crediting Indigenous Peoples for the knowledge taken from them (Martin, 2012; Snively & Williams, 2016). The perceived superiority of Euro-Western science has typically resulted in Indigenous Peoples having a lack of control over or minimal participation in the creation of research projects that have direct impacts on them. Indigenous Peoples have been thrust into research endeavours, mainly being conducted by Euro-Western researchers (see, for example, Oudshoorn, 2019 or Mosby, 2013) without informed consent and without any benefits to the communities themselves. As a result, Indigenous Peoples are understandably skeptical of research being done on them and within their communities and this type of research has been a driving force behind calls to **decolonize research agendas.** Decolonizing research emphasizes practices that challenge research that perpetuates colonialism and is derived from colonial ideologies and values (Smith, 2018) while also ensuring that the research conducted is done *with* and *by* Indigenous Peoples, rather than *on* them. In the case of the current study, moving towards a decolonized research agenda creates space for research that is driven by the Indigenous occupational therapist community, centering our Indigenous knowledges and worldviews during the research process. As such, although the findings of this study are important and needed in the profession, *the process,* meaning how the research takes place, is equally as important.

A **guiding principle** that may assist in conducting meaningful and respectful engagement with Indigenous OTs and their worldviews is *Etuaptmumk*. Given that I am Mi'kmaq, and Etuaptmumk was originally put forward by Mi'kmaw Elders and others in

Mi'kma'ki, it was decided that this guiding principle would fit nicely with the goals and objectives of this dissertation.

Etuaptmumk

There are numerous ways of seeing the world – and above I have outlined two core worldviews that are influential in this study. A guiding principle for understanding how we make sense of multiple perspectives and worldviews is Etuaptmumk. Etuaptmumk was created by Elders Albert and Murdena Marshall, and Cheryl Bartlett with inspiration from the late Charlie Labrador, Mi'kmaw Spiritual Leader, healer, and Chief of Acadia First Nation. The concept of "Trees holding hands", discussed by Labrador, emphasizes that we as people must work together, support, and respect each other in order to meaningfully share knowledge. Etuaptmumk notes that Indigenous knowledge and epistemologies are entirely separate from Western knowledge and epistemologies, and there is an imperative to use both knowledge systems to better society (Bartlett, Marshall & Marshall, 2012). Etuaptmumk is the Mi'kmaq word for multiple perspectives (Roher et al., 2021). The guiding principle of Etuaptmumk pays deep respect to Indigenous knowledge systems as stand-alone from Western and has resulted in a plethora of new possibilities for knowledge generation when we begin to understand the value of multiple perspectives. Etuaptmumk is described as bringing forward ways to understand the world that could not be otherwise gleaned from only one worldview (Bartlett, Marshall, & Marshall, 2012). Etuaptmumk presents a sophisticated way to recognize that diverse perspectives are a gift and that, if we are able

and willing to acknowledge the presence of those gifts, then we can move forward in a way that generates new and innovative understandings of the world.

Etuaptmumk is described as a respectful co-learning process (Roher et al., 2021) that is foundational in ensuring that the research reflects "communities 'beliefs, values, and ways of knowing, being, and doing" (Sylliboy et al., 2021, p. 3). However, in order for respect and co-learning to truly occur, I believe there is a requirement for a relinquishing of power on behalf of settlers, who have held a monopoly over (legitimated, recognized, authoritative) knowledge generation and production through colonial systems. This means that a commitment to the process, or the conversation must be seen as equally as valuable as the outcomes of the work being undertaken – if not more valuable (Roher et al., 2021). Sylliboy et al. (2021) provide eight guidelines that represent the entirety of the research process (e.g., relationship building, capacity development, etc), and these guidelines support researchers to effectively consider and utilize Etuaptmumk in Indigenous health research. These guidelines provide a framework for this research process, ensuring that Etuaptmumk is considered as a guiding principle throughout the process. In the context of this study, Etuaptmumk asks that the OT profession recognize, respect, and utilize Indigenous ways of knowing to better support the practitioners and clients it aims to serve. This requires a breaking down of dichotomies of 'this or that' (Aikenhead & Ogawa, 2007) towards a more integrative understanding of the utilization of multiple knowledge systems for the betterment of all. What is apparent in the use of Etuaptmumk is that much of the work in this case must come from settlers and extracting the 'best of both knowledge systems' requires extensive engagement and involvement

among members of virtually every aspect of the profession (e.g., practicing OTs, regulators, educators, students).

Considering and utilizing multiple perspectives

For the purposes of this study, deep consideration for both Indigenous and Western worldviews is important. The context is the occupational therapy profession, which is situated as a health profession, yet operating outside of the typical biomedical model that governs most others, while it also has core features that align with Indigenous epistemologies. The OT profession is uniquely positioned as it is both within the colonial health care system but also demonstrates a challenge to it through some of its core values and principles. Methodologies and methods of inquiry in this work considered both Indigenous and Western-derived processes to describe and analyze the experiences of Indigenous Peoples who have been educated in colonial education systems and then subsequently worked as OTs in the colonial health care system in Canada. Efforts to center Indigenous knowledges, particularly how they are (or are not) used currently by Indigenous OTs in the profession helps inform actionable recommendations for the profession to improve – utilizing the guiding principle of Etuaptmumk to consider differing perspectives. The profession will arguably never entirely be grounded in Indigenous worldviews or epistemolog; however, the deliberate exclusion of Indigenous knowledges has done a disservice not only to clients and practitioners who come from equity-seeking groups who do not represent the majority but to all clients and practitioners. To address the TRC (2015) and MMIWQ2S (2019) calls to action and justice, the profession has a duty to understand Indigenous perspectives and actively engage

with Indigenous practitioners to enact meaningful change and use their knowledge systems actively within the profession.

Research questions

The research question guiding this work is: *How do Indigenous Peoples experience working as occupational therapists in Canada?*

My work explored the following sub-themes:

1. How everyday work experiences of Indigenous OTs has been shaped by their Indigeneity in the context of a colonial profession;
2. How Indigenous OTs employ Etuaptmumk [Two-Eyed Seeing] (Bartlett, Marshall & Marshall, 2012) in their everyday practices;
3. How the social processes of inclusion and exclusion influence their practice;
4. How professional context shapes experiences of belonging and marginality; and
5. How Indigenous OTs advise the profession in change efforts, ranging from Indigenous inclusion towards actual decolonization (Gaudry & Lorenz, 2018)

These themes were collaborative decided by myself, my supervisors, as well as my committee members.

Methodology & study design

This research was participatory in nature and employed Indigenous methods (Indigenous storytelling and sharing circles) as well as aspects of critical autoethnography to ensure my own perspectives were integrated into the research in a useful way, given

that I am an Indigenous OT and also have perspectives to contribute to this research topic.

Participatory forms of research

Community-based participatory research (CBPR) is an approach to research which advocates for active consultation with and involvement of communities in the research taking place about them (Wallerstein et al., 2018). This popular research approach includes active community participation (Wallerstein & Duran, 2018) and acknowledging racism and privilege (Muhammed et al., 2018); it is typically action driven. However, it is important to note that CBPR is subsumed under a transformative framework, created from a Euro-Western worldview to challenge traditional mainstream research as unidirectional and top-down (Wallerstein et al., 2018). This means that it may align with but does not entirely encompass, Indigenous worldviews. Nonetheless, scholars engaged in Indigenous research often take pieces from CBPR guidelines and adapt them (e.g., Morton Ninomiya & Pollock, 2017) for suitability with the unique communities they are working with. As such, it is important to note that when we use Western research methodologies and methods in Indigenous health research, there will always be an underlying tension stemming from different epistemologies, ontologies, and subsequently the worldviews that guide the research.

CBPR is particularly popular for use with Indigenous Peoples and communities given its flexibility and the opportunity for collaboration among the researchers and the participants. It is described as having the potential to address a wide range of health disparities experienced by Indigenous Peoples and communities (Castleden, Garvin &

Huu-ay-aht First Nation, 2008; Dadich et al., 2019), and moves away from the way research has historically been done on Indigenous Peoples and communities (Christopher et al., 2011). The idea of community-based participatory research aligns with ensuring the community is actively involved from the onset of the research project (conceptualizing the questions/topic) all the way through to knowledge dissemination plans and activities. Thus, it is a way for Indigenous Peoples and communities to assert greater control over the research process.

Tensions outlined in the literature include the notion that 'participatory' is left up to the researchers (Dadich et al., 2019), which could result in inadequate collaboration resulting in harmful research, a situation that has been outlined extensively by scholars using this paradigm with Indigenous communities (e.g., Castleden et al., 2012; Morton Ninomiya & Pollock, 2017). Another tension includes what, and who, constitutes community, given that no community is homogenous, and the voices of community leaders or others may not represent the interests of the community (Wallerstein & Duran, 2006). In relation to my own research, the major tension I envisioned coming into play was the Euro-Western processes and requirements from the academy (particularly, PhD requirement processes) and the needs and desires of the Indigenous OT community with whom I would work. In particular, a PhD is assumed to be a solo endeavor, however, my PhD work has been a collaborative compilation designed to initiate meaningful change for Indigenous OTs – derived directly from their experiences and opinions. This meant that I had to find unique ways to address both my own degree requirements while ensuring my research is community-driven and includes active participation of

participants as much as possible. This tension arises from differences in worldviews, and throughout this work participants shared an understanding for the need to straddle two worldviews as I fulfilled my own PhD requirements while trying to ensure that the project and its processes and outputs were what is needed for the community at this time. This meant that if the goals and outcomes of my own research became incompatible with the requirements of my program, there would be a need to push back at the university and remind them of their commitments to meaningful Indigenous engagement and decolonizing. For example, the timeline of my PhD research in relation to engagement has taken longer than what is considered standard, the outputs of my work are anticipated to focus more on the background work needed to begin this Indigenous Community of Practice (CoP) and less focused on academic outputs (e.g., peer-reviewed articles). These commitments were supported by both of my supervisors who already engage in critical questioning of the institution in which they work.

With this knowledge of the strengths and tensions of CBPR for Indigenous health research, I used aspects of this approach in my doctoral study. As mentioned above, Etuaptmumk is a guiding principle, emphasizing the need to consider multiple perspectives and utilize these diverse perspectives to improve society (Bartlett, Marshall & Marshall, 2012). The participatory nature of this approach lends itself well to core aspects of Indigenous methodologies and highlights the need to halt research done *on* Indigenous Peoples, shifting to research done *in partnership* with them, with the ultimate goal having research that is *by* Indigenous Peoples. As such, I utilized participatory

methods in this study and was guided by how engaged the community within this research would like to be, and at what stages throughout the process.

Indigenous storytelling

Indigenous storytelling, or storywork as termed by Archibald (2008), was used to guide the process of collecting stories throughout this study. Indigenous storywork shares many similarities to Western narrative research, which includes the collection of personal experiences and stories of individuals (Creswell, 2018), yet important differences in these two methodologies are apparent. Thus, this work situated an Indigenous methodology at the forefront, in keeping with efforts to decolonize the research process. Although both narrative inquiry and Indigenous storytelling focus on the lived experiences of individuals as well as the role of the researcher in the creation and collection of these narratives, Indigenous storytelling stems from Indigenous worldviews and an oral culture – differentiating it at the levels of ontology and epistemology. It is here, in the epistemological underpinnings of Indigenous knowledge such as the importance of place and context, relationality and reciprocity, holism, and the oral nature of Indigenous knowledge sharing that narrative inquiry and Indigenous storytelling are set apart. Authors have noted that subsuming Indigenous storytelling under the auspices of narrative inquiry runs the risk of placing it under a Western worldview (Penak, 2018; Graveline, 2000), and as a result I felt it was important to derive my methodologies and subsequent methods from within Indigenous worldviews. For the purpose of this study, key underpinnings of Indigenous knowledges were centered and integrated into virtually every aspect of the research process (initial relationship building,

storytelling sessions, data analysis, and the sharing of the findings) to move towards conducting this research through an Indigenous worldview.

Indigenous storytelling was used to guide my individual interactions with study participants. Indigenous storytelling heavily emphasizes the role and responsibility of the listener and the multiple meanings a story may hold depending on the context in which it is told (Archibald, 2008). In this study context, I simply asked participants to share their stories with me from their experiences pursuing post-secondary health practitioner education to their everyday workplace experiences. Through this data collection, I found that many experiences shared with me resonated with my own personal stories – giving great power to the collective journey of storytelling between the listener and the storyteller. These individual stories were collected as they were told, and efforts were made throughout the data analysis and findings to keep these stories intact, an important factor for using Indigenous storytelling in research (Archibald, 2008). This is apparent in the collective stories created in Chapters 4-6. The purpose of creating a story within each chapter that encompassed many of the everyday experiences shared was to allow readers a better understanding of the cumulative nature of negative experiences that Indigenous OTs have gone through, as well as highlighting the impacts of everyday discrimination and exclusion on Indigenous OTs.

Sharing circles. Additional to the individual storytelling sessions, sharing circles were used to bring together diverse experiences and perspectives to deepen analysis and understandings. Our two-day sharing circle had a Mi'kmaw Elder present to conduct an opening ceremony, participate in the discussion, as well as close the sharing circle

gathering in a good way. Many Indigenous Peoples have used sharing circles as a method of sharing information through stories for thousands of years (Lavallée, 2009). The protocol for a sharing circle varies widely among communities (Hunt & Young, 2021), but a key feature of most sharing circles includes providing a supportive environment for everyone participating to express their opinions, perspectives, and emotions without being interrupted or stopped (Rothe et al., 2009). Collective sharing and decision making allow for meaningful, lasting solutions to be identified, as well as support a broad understanding of the issues at hand (Rothe et al., 2009). Sharing circles are grounded in Indigenous epistemologies and thus honour Indigenous oral traditions and interaction styles that are uniquely derived from Indigenous worldviews (Lavallée, 2009; Rothe et al., 2009). They also are deeply emotional or spiritual, and participants are recruited personally and gather at a spot that is culturally significant (Rothe et al., 2009). Given that they adopt the principle of no interruption, putting a time limit on a sharing circle is not necessarily a suitable option. As such, my research adopted a sharing circle methodology, in line with Indigenous worldviews and Indigenous epistemologies.

Critical autoethnography

Autoethnography is a form of Western qualitative research in which a researcher uses self-reflection and writing, plus potentially other methods, to connect their own personal thoughts, feelings, and experiences to broader political, social, and cultural understandings of the world (Ellis, 2004). Described as method of therapeutic 'talking cure' by Tomaselli, Dyll and Francis (2018), autoethnography in this sense involves a complex blending of experiences among the participants and the researcher – breaking

down the duality of researcher/participant. This duality of researcher/participant is blurred in this study, as I am an Indigenous occupational therapist exploring questions regarding experiences within the profession – questions on which I too have perspectives to share. As such, this study moves past autoethnography towards a paradigm of critical autoethnography.

Critical autoethnography is described as an innovative approach to ethnographic research, particularly within equity-seeking communities (Tilly-Lubbs, 2014). This approach moved past a telling of my own story to include integrating my own experiences, perspectives, and identity into the research (Creswell, 2018), toward a blending of autoethnography, ethnography and critical inquiry to situate me as researcher and as an active participant in the study at hand (Tilly-Lubbs, 2014). This was done through not only considering the ways in which my own experiences connect to broader processes and understandings of the world, but centered on the notion of identity and how this also influences the ways in which I received and subsequently interpreted the stories of participants in this study through that lens (Boylron & Orbe, 2020). Throughout this work, I was aware that I had to critically consider how my own experiences as an Indigenous OT are situated in a web of social, political, and cultural relations and experiences, which inevitably impact the entirety of the research process.

As such, throughout this study, I conceptualized myself equally as a researcher and participant. To do this, I asked one consultant on this project to guide me through a storytelling session so that my story became one of many participants stories in this research. During the sharing circle, I facilitated the conversation during the gathering but

also included my own perspectives, actively participating in the discussion, and presenting my preliminary Stage 1 data analysis to the group, so my perspectives and opinions became one portion among many other perspectives and opinions. Nonetheless, integrating my own experiences, perspectives, and identity into the research makes evident the inherent risk of bias in any research, as study analyses are inevitably affected by researcher opinions, perspectives, and experiences. The unexamined effects of bias were minimized in my research through collaborative data collection and data analysis procedures during the sharing circle. For example, I conducted the storytelling sessions with participants and analyzed the data individually first, and then brought my initial thoughts to the sharing circle gathering (made up of participants from the individual storytelling sessions) to ensure that the findings represented the collective narrative. It is also important to note that as I was formulating preliminary themes, ongoing discussion with participants and project advisors occurred in both formal and informal ways. I continually worked alongside participants to co-develop themes and engage in data analysis collaboratively. The notes from the sharing circle gathering were recorded when necessary and transcribed verbatim. A group of Indigenous OTs collectively presented some of this work at the 2023 CAOT Conference, and during that process feedback was integrated and collaboration continued on further iterations of data analysis. During the 2023 CAOT Conference, I also gathered with several Indigenous OTs to again have a conversation regarding this PhD project, and the progress to date, soliciting perspectives on ways to present this work in a written dissertation form.

Gaudry and Lorenz (2018) framework for storywork and sharing circles

As described above, Gaudry and Lorenz (2018) have outlined the only framework to date that contextualizes Indigenization and decolonization efforts in the academy in a tangible way. They propose this framework using a three categories of action that can be conceived along a continuum: Indigenous inclusion supports increasing Indigenous participation, and subsequent adaptation, into current structures; reconciliation Indigenization includes bringing together Indigenous and Euro-Western knowledges to develop new understandings and support relationship-building between institutions and Indigenous communities; and decolonial Indigenization refers to a complete overhaul of structures and institutions to balance power relations, creating something dynamic and new, meeting the needs of all. This framework provided a helpful way to categorize efforts and subsequently frame progress made.

This framework was used during the sharing circle sessions to contextualize efforts seen by participants during their clinical work as well as efforts they have seen or experienced while pursuing occupational therapy training. I used this framework to encourage participants to think critically about the efforts they have seen from the profession in relation to Indigenous health, reconciliation, and decolonization, while also providing a 'jumping off' point for participants to envision what a decolonized occupational therapy profession may look like. For example, do efforts toward recruitment and retention of Indigenous OT students constitute inclusion politics, and what might a decolonized recruitment and retention process look like? Flexibility was employed and discussed with Indigenous OTs taking part in this research to provide a *lay*

of the land in relation to Indigenization and decolonization efforts in the occupational therapy profession. Importantly, this this framework helped structure a presentation by several Indigenous OTs at the 2023 CAOT Conference critiquing the profession's efforts to date.

Community engagement

Community consultation is key to the ethical conduct of this research study. In 2018, the three national funding agencies for research announced the second edition of their guidelines for ethical research involving humans in their Tri-Council Policy Statement (TCPS): Ethical Conduct for Research with Humans, with Chapter 9 titled "*Research Involving the First Nations, Inuit and Metis Peoples of Canada*" (CIHR, NSERC, & SSHRC, 2018). This chapter highlights the minimum requirements one needs to abide by when conducting research with Indigenous Peoples in Canada, largely spurred by past historical practices of unethical and harmful research with Indigenous Peoples (Mosby, 2013). Notably, Article 9.2 refers to the need for community engagement in research that has implications for the lives and wellbeing of Indigenous Peoples and notes that, "The nature and extent of community engagement in a project shall be determined jointly by the researcher and the relevant community and shall be appropriate to community characteristics and the nature of the research" (pg. 113). Sylliboy et al. (2021) provide concrete recommendations for using Etuaptmumk in Indigenous community-engaged research specific to Mi'kma'ki, and provide key steps to take when developing and maintaining Indigenous research partnerships such as capacity development as reciprocity, and considering Indigenous research by design throughout the process.

These guiding principles were considered throughout this research project to ensure the community was actively involved and their input was captured and valued throughout the entirety of the research process.

The motivation for this project stems mainly from numerous conversations with Indigenous OTs over the past 3-4 years, as well as my own perspectives and observations as an Indigenous OT. Community can be defined very broadly and may be defined differently in various settings and contexts. In this case, the community in question are the Indigenous OTs in Canada. Although many Indigenous OTs are already familiar with my doctoral research through various informal conversations at meetings, conferences, or other projects, I provided an overview of the research with the two consultants on this project to gather suggestions for key areas or topics that should be discussed during the storytelling sessions. I utilized my existing connections through the emergent Indigenous OT CoP and the Occupational Therapy and Indigenous Health Network (OTIHN) to share this co-created research and advertise for participation and partnership.

However, community in this context may be particularly different given colonialism, colonization and white supremacy in the context of Indigenous identity. Although I am very familiar with Indigenous OTs who are comfortable self-identifying and have done so in a public forum, I anticipated there were other Indigenous OTs who perhaps have not self-identified in a public way and who might not participate in the formal Indigenous networks already active. Therefore, I recruited Indigenous OTs who self-identified as such, or who are Indigenous but choose not to openly self-identify in every space they engage in, for various reasons. It was important to me to gather the

perspectives of these OTs who may not openly self-identify, especially if they expressed an interest in the research study. In particular, I was interested to know **why** they do not publicly self-identify, and whether they still experience tensions relating to their own Indigenous ways of knowing and the Euro-Western worldview of the profession. I also felt they would have valuable information to share on cautions and advice for the profession, especially if they felt they needed to hide their identity to be an OT. I recognized that these Indigenous OTs would be harder to reach, and I hoped that through widely sharing my recruitment poster and other details about this work that I would reach these OTs despite their not being involved in formal Indigenous professional networks. Interestingly, many of the Indigenous OTs recruited did not participate in the formal Indigenous professional networks for a wide range of reasons.

In line with the need for community engagement when conducting research with Indigenous Peoples outlined in the TCPS2, the community of Indigenous OTs have been the driving force for this study and have been continually engaged throughout this research. This research is community-driven and has been done in partnership with this community to ensure the research meets the needs of Indigenous OTs and can provide actionable recommendations and suggested changes.

Ethics approval for this research study was received by Mi'kmaw Ethics Watch and the Dalhousie Research Ethics Board (REB).

Recruitment

Participant selection. Participants for this study were recruited by purposive sampling and snowball sampling. Purposive sampling is when the researcher deliberately

chooses individuals who meet the inclusion criteria of the study and are likely to be 'information rich cases' (Creswell, 2018). In other words, individuals are chosen for a purpose; sometimes because they are expected to bring desired variation to the sample (e.g., types of practice settings, or years of practice experience), sometimes because they are expected to be highly able to reflect on and articulate the experience sought, sometimes because they are likely to fill a gap in information obtained to date. Snowball sampling is a recruitment technique where the researcher identifies initial participants who then are asked to assist the researcher in identifying any new potential participants who meet the outlined inclusion criteria for the study (Creswell, 2018). It can lead to undesired homogeneity in a sample, as people recruit others like themselves, but this can be countered by asking participants to forward study information to those like and very unlike themselves, with regard to the study focus. Both methods are important given that I have direct knowledge of many Indigenous occupational therapists in Canada, which was important for purposive sampling, but there are some I did not know, therefore others may act as an important connection to these individuals through snowball sampling.

In this study, participants who self-identify as Indigenous (e.g., First Nations, Métis, or Inuit), or who are Indigenous but choose not to openly self-identify beyond the research context for various reasons were included. Participants had to be registered occupational therapists in Canada. No restriction on area of practice or type of employment was set to ensure that the findings represented experiences across vast geographic and practice contexts. No limit was set for the number of participants who

could participate in an individual storytelling session given the small number of Indigenous occupational therapists in Canada; ultimately 13 storytelling sessions were conducted. A limit of 10 Indigenous OTs was set for the in-person sharing circle gathering due to financial constraints, with a minimum of 5 OTs needed to go forward with this gathering. This was determined based on the scope of the study (national) and to ensure a diversity of perspectives. In the end, eight Indigenous OTs participated in the sharing circle gathering. This sample size was chosen in part to ensure active collaboration among attendees regarding themes from Stage 1 of this research was feasible while also capturing diversity of Nations and Peoples across the country.

In this study there were two distinct 'communities' involved – those who are currently part of an Indigenous OT CoP that is beginning to emerge as well as the broader Indigenous OT community. The work grew out of conversations among a small group of Indigenous OTs who have collaborated in various ways over the previous 3-4 years in an informal community of practice. Two of those therapists served as consultants or advisors for the project, and the group provided a sounding board as the project unfolded, plus will have distinct data ownership.

Recruitment strategies. Two key recruitment strategies were used for this study. The primary recruitment strategy was talking directly to Indigenous occupational therapists involved in the emergent Indigenous CoP group, along with therapists involved in the OTIHN from the Canadian Association of Occupational Therapists (CAOT). I have been actively involved in the inception of and presentations relating to the need for an Indigenous OT CoP, and am a member of OTIHN, therefore both recruitment strategies

proved beneficial. I shared this study information at meetings for both groups and invited those interested and who met the inclusion/exclusion criteria to contact me directly for further information.

The second recruitment strategy included creating a poster to circulate through various networks (e.g., the listserv for OTIHN, the e-digest of the Atlantic Indigenous Mentorship Network, as well as my own social media accounts). This recruitment strategy was also important given that I would not be acquainted with all the Indigenous OTs across the country, and this method cast a wider net to ensure I did not miss anyone who may have been interested.

Research methods

There were three types of knowledge gathering mediums in this project: individual storytelling sessions, an in-person sharing circle gathering, and my own critical reflections and personal observations. Informed (ongoing) consent was obtained during all encounters with participants. In particular, the sharing circle gathering included a conversation surrounding involvement in this project, co-authoring work, as well as the potential loss of confidentiality by becoming identifiably involved with the Indigenous CoP. Participants were made aware that they can withdraw their consent at any point without adversely affecting the researcher and participant relationship.

Story-telling sessions. Initial participation in this study asked Indigenous OTs to participate in one informal, one-on-one story-telling session with me. These were done in person, over the phone, or via Microsoft Teams depending on the location of the participant. Participants were asked general demographic questions such as how long

they've been in practice, location, and practice setting. The majority of these sessions occurred via distance given that most Indigenous OTs live outside of Nova Scotia, where I am based. In terms of a sample size, I envisioned a suitable sample size for this project to be between 10-15 participants, and therefore decided I would choose the first 10-15 interested volunteers who reached out to me for inclusion. This sample size was chosen to ensure a range of experiences and perspectives. I conducted 13 individual storytelling sessions with Indigenous OTs; at that point no new potential participants came forward and I judged that I had attained thematic saturation. This method of data collection was chosen for two reasons; 1) it fits within Indigenous worldviews and represents the guiding principles of the study better than standard Western interview methods; and 2) Given my relationship with many of the Indigenous OTs in Canada currently, this method represents the ways we have communicated and passed on knowledge in past meetings and conversations. These sessions were audio-recorded and semi-structured in nature, utilizing a co-developed set of themes/topics to be covered based on input from the two Indigenous OT project advisors.

At the onset of this study, I drew on the current network of Indigenous OTs I am a part of and determined people's availability/interest to support me in drafting key questions or areas of inquiry. Having a set of themes or topics to be covered was important to ensure that the information gathered supported the study questions and objectives, but also allowed the participant flexibility to share their ideas and guide the story-telling process. Each individual story-telling session (myself and a participant) was between 1 to 2 hours in length. These individual sessions focused on the story of the

participant, not myself. My own story was captured through asking another Indigenous OT to conduct a session with me and ask me regarding the themes/topics. Participants were asked if they felt comfortable having their story recorded, and all agreed. Stories being told in person or over the telephone were recorded using an external audio-recorder, whereas those being told virtually were recorded using Microsoft Teams. Audio recordings were transcribed verbatim by a transcriber. Participants were provided the opportunity to review their transcribed storytelling session if they wished.

Sharing circle gathering. Given that one of the objectives of my research was to hear directly from Indigenous OTs on their experiences, perspectives, and recommendations to facilitate meaningful engagement (e.g., moving beyond mere 'inclusion' towards decolonization [Gaudry & Lorenz, 2018]) of Indigenous Peoples and their knowledges in the profession, it was important to bring together a group of interested Indigenous therapists to collectively develop ideas for change. As such, this research included a two-day, in person sharing circle gathering in Halifax, Mi'kma'ki. Eight Indigenous OTs provided feedback on the preliminary themes from Stage 1, shared their experiences and knowledge, and discussed broad issues within the profession.

An agenda for these two days was co-developed with two Indigenous OT consultants (see Appendix B). The main objectives for this gathering were twofold: 1) to deepen the analysis for my doctoral dissertation and 2) to provide a forum for exploring possible directions for an Indigenous OT Community of Practice. The gathering consisted of formal data gathering and guided discussions, some of which were recorded (i.e., when people responded to my preliminary analyses of the storytelling sessions). Other

informal networking sessions, as well as discussions over food, were not formally recorded but captured in my personal observations (see below). During this gathering, there were significant brainstorming and discussions, which were captured by notes taken on a laptop. Upon finalizing the agenda for this gathering, the agenda was distributed to participants indicating which agenda items were being recorded and which were not to gather their consent for each recorded session. During the gathering, consent was rediscussed each time prior to the recording device being turned on.

Personal observations. Personal observations and reflections were captured throughout the duration of this study. This was done in three ways. The first is through a daily research journal where I chronicled my personal thoughts, ideas, and observations at the end of each day during the data collection phase of the research project. This journal was particularly helpful to remind me of past events, thoughts, tensions, and observations that may have been forgotten had I not captured them in writing. These notes were reviewed throughout the data analysis phase of this work to inform my thinking. The second method of capturing my personal observations was through field notes at the end of each storytelling session as well as at the end of the 2-day sharing circle gathering. These field notes helped capture aspects such as felt tensions, body language, observations, and anything else that stood out to me. Field notes were captured as soon as possible after the storytelling or talking circles had taken place. Finally, I had another Indigenous OT conduct a storytelling session with me, using the same questions/themes that were being used to guide the other storytelling sessions. My storytelling session was treated as data like the others, meaning it was read and reread

and preliminary ideas and themes were extracted and placed into a Word document alongside information from the other sessions.

Data analysis

Data analysis for this research study was done in collaboration with Indigenous OTs in this study. First, I compiled all the data and uploaded it into Atlas.Ti8. Data was reviewed in Atlas.Ti8. I began by identifying preliminary codes, and then took those codes and began categorizing them into preliminary themes on Microsoft Word and Bristol board for review. In the initial conceptualization of this project, I was planning to use both thematic and narrative analysis, as there is utility in both depending on the sub-question(s)/topic(s) being addressed. I anticipated using narrative analysis primarily for data from the storytelling sessions regarding experiences, as narrative analysis does not require that the researcher break down individual stories into component parts. However, upon discussing the use of narrative analysis at the sharing circle gathering, participants did not want the entirety of their stories shared and expressed concern with this method. Therefore, narrative analysis was not used to keep the stories intact. Instead, it was collectively decided that I would capture key experiences through the creation of common stories that illuminated a collective experience related to each topic, rather than keeping the stories individual in nature.

Thematic analysis. Thematic analysis is a method of data analysis that allows researchers to identify themes across their data set. Known for its flexibility, it allows researchers to sift through their data and deconstruct it into codes and subsequent themes, with steadily deepening levels of analysis (Braun & Clarke, 2006). The data were

reviewed and organized using thematic analysis as proposed by Braun and Clarke (2006), who outline a 6-phase process that includes familiarizing yourself with the data, generating initial codes, searching for themes, reviewing themes, naming and defining themes, and producing the report.

Thematic analysis has been critiqued within Indigenous methods literature since it involves taking stories apart instead of keeping them whole, however, it was helpful for addressing some of my research questions (topics 2, 3 and 4 above). These points of inquiry were well suited to identifying patterns within the data and generating codes that represented the social and professional contexts and processes that shaped participants' experiences. Thematic analysis was particularly useful as I employed Gaudry and Lorenz's (2018a) framework to contextualize the cautions and advice emerging directly from Indigenous OTs to make changes within the profession.

I began analysis using Atlas.Ti8 by creating codes for reoccurring concepts observed in the data. I then moved the data to Microsoft Word and on Bristol board to begin creating preliminary themes. Upon generating preliminary themes, I discussed these with the two Indigenous OT project consultants for further refinement. After this initial discussion, themes were modified, reviewed, and named and then presented to the group of Indigenous OTs at the sharing circle gathering for further input, as well as again at the 2023 CAOT Conference for Indigenous OTs in attendance. Changes were incorporated after both discussions. Active participation in the data analysis phase was important given that this work will form the basis of an emerging Indigenous CoP, which will likely use this data directly to guide its activities and priorities.

Narrative analysis. As noted above, my use of narrative analysis did not turn out as anticipated, but one of its key values is in ensuring the stories of Indigenous OTs remain *in context* (Hall, 2015) – aligning with Indigenous worldviews. One of my research focuses concerned understanding the everyday experiences of Indigenous OTs in relation to studying and working in a colonial health profession and health system. In Chapters 4, 5 and 6 short, fictionalized accounts introduce the results and analysis, to convey the cumulative nature of multiple experiences in context. They draw on the stories across all participants but are not the individual story of any one participant. The intent is to convey the relentlessness of colonial oppression within the profession.

Ethical considerations

As noted previously, this project obtained ethical approval through both Mi'kmaw Ethics Watch and the Dalhousie REB.

Informed consent. When a potential participant contacted me, I confirmed their eligibility to participate (using the eligibility criteria outlined above) and then I sent the consent information via email. Since almost all of the storytelling sessions were conducted via distance (phone, Microsoft Teams) – I discussed the consent form at the outset, addressing any questions prior to commencing the session. Consent was recorded via the recording device (recorder if conducting it on the phone, the 'record' function on Microsoft Teams). For those who participated face-to-face, I gathered informed consent orally and wrote down the date and time this was received or obtained their signature.

Risks and benefits. Within this study there were two major risks – privacy and emotions. Indigenous OTs are vastly underrepresented in the profession and for this

reason, they could be easily identifiable, resulting in the risk to privacy being high. Those who wished to remain confidential could participate in individual storytelling sessions, but not participate in the in person gathering, or join the Indigenous OT CoP that is emerging from this project. Those who attended the sharing circle gathering were obviously known to one another, and those who are publicly affiliating with the CoP will be known and may be assumed to have participated in this research. Everyone knew that limit to confidentiality. Certain demographics are masked in the reporting of the results such as area of practice or province of employment to mitigate Indigenous OTs being easily identified.

At times, sharing experiences within the profession, including experiences of social exclusion and marginality, elicited complex emotions. When this occurred, I assessed the situation and offered the participant a break, asked if they wish to continue or not, quietly listened and offered empathy from one Indigenous OT to another, and ensured they were okay prior to moving on or ending the session. Participants were given the flexibility to process and engage with difficult or complex emotions as they wished. Archibald (2008) discussed the importance of "letting our emotions surface" (pg. 8) during the storytelling process, and this principle was welcomed and emphasized as an important feature prior to engaging in the storytelling or sharing circle sessions. A local Mi'kmaw Elder was present throughout most of the sharing circle to provide supports and guidance as needed to the group.

The benefit of this research for participants lies in the use of the data as the basis for work being done by Indigenous OTs who would like to develop an Indigenous OT CoP.

Data from this study will be used to develop directions for the profession, as well as share stories of the experiences of Indigenous OTs in the profession. It is hoped that Indigenous OTs who are seeking a community of support will have some needs met through the study outcomes.

Data storage. The audio files for each storytelling session were uploaded onto my computer, and password protected, then uploaded to Microsoft Teams for transcription. The transcriber signed a confidentiality form. Upon receiving the transcript, I deidentified the audio files by assigning the transcript a file ID (e.g., OT8) and read the transcript in full and removed/flagged any identifiable characteristics. Where context was important to the quote, I left it in the transcript but flagged it as potentially identifying information to ensure this information does not get published. A copy of each transcript was put on an encrypted external hard drive in a locked storage cabinet in my office which is located on the 5th floor of the Collaborative Health Education Building (CHEB). All audio files were deleted from Microsoft Teams immediately after they were received from the transcriber.

Given the collaborative nature of this project, it is important to note the varying levels of confidentiality embedded within. I maintained confidentiality of the data and de-identified it. No one was involved with analyzing the data without a signed confidentiality form. However, if participants wish to participate in any future publications or knowledge dissemination, their confidentiality is at risk, a limitation made known to them in advance. The names of participants are being kept confidential based on the decision of the group during the gathering.

Data ownership. Given that this project stems from an expressed desire to develop an Indigenous CoP, the data from this study are owned by both myself and the emerging Indigenous CoP. However, it is important to note that group members have access only to the de-identified data (initial codes, themes) and not the raw transcripts to maintain the privacy and confidentiality of the participants. This was further discussed at the in-person sharing circle gathering, and it was decided that guidelines and parameters for the use of this data among the CoP will need to be collaboratively developed. This work will be ongoing, long after my PhD is complete.

Knowledge translation. The knowledge translation pieces derived from this project will serve multiple purposes. First, my PhD dissertation is solo-authored, however, the analysis process has been collaborative with all interested participants of this research study. Any knowledge translation that stems from this project (conference abstracts, peer-reviewed articles, public knowledge sharing) will be done through consultation and seeking feedback with any interested Indigenous OTs who have participated in this study. I will always list the Indigenous OT CoP as a contributor on any other knowledge dissemination activities unless members say otherwise, with individuals being named as specific co-authors if they contribute to the writing and presenting of the work. Further, I will continue to invite any other participants from this project to contribute to conference abstracts, peer-reviewed articles or public knowledge sharing if they wish to do so.

Other considerations

Doing Indigenous research via distance. Relationality and relationality accountability (Wilson, 2001) are guiding features of Indigenous epistemologies. Further, literature demonstrates that of key importance when conducting Indigenous health research is to have an authentic, respectful relationship with the community (Bull, 2010). To date, research on doing community-based Indigenous health research via distance is limited, however, a recent article by Bujold et al. (2021) shows promise in utilizing virtual platforms to conduct community-based research. However, issues of access and expertise on doing this work virtually were noted. Nonetheless, they conclude that technology does not need to be solely a "Western" resource, and it has value in the context of Indigenous Peoples sharing and celebrating their culture. Outside of the Indigenous health research context, Tami-Maury et al. (2017) echo the findings above regarding the unique utility of virtual 'communities' in relation to CBPR projects as they reduce barriers (e.g., geographic). This is relevant given that the individual sessions of this research study were conducted via distance as very few Indigenous OTs currently reside in the same province as I do. Studies on distance learning and relationship building points to difficulties in building meaningful relationships in comparison to learning done in-person (Martin, 2019), which in research endeavours may be compounded by the negative history of colonial research that did more harm than good.

While I cannot know how the research might have differed if conducted entirely in person, I hope concerns were at least in part mitigated by my membership in and close relationships within many members of the Indigenous OT community across Canada. Many of the Indigenous OTs I have worked with over the years are also now considered

my friends, and many of them I have worked with via distance since we became acquainted. I hope that although relationship building with new Indigenous OTs who I met throughout this study might be slower, my connection with this community already fostered a sense of comfort and shared understanding that supported relationship building. In contrast to the individual storytelling where distance formats allowed participation across Canada, it was important to hold the sharing circle gathering (Stage 2) in person to foster connection and begin building relationships. This was especially valued given the desire to use that gathering as a springboard for an ongoing CoP.

Confidentiality. Some data collected in this study are confidential – individual experiences shared with me were de-identified and careful consideration took place throughout the writing of this dissertation to mask identifiers. However, given that an action component of this project is the advancement of a funded Indigenous OT CoP, Those who have been and will continue to be involved in that initiative will inevitably be identifiable. Prior to beginning the research, six Indigenous OTs have been engaged in these efforts, are well known in the OT community and have presented on this topic at CAOT conferences. I will continue to acknowledge the six of us currently involved in developing an Indigenous CoP on all knowledge dissemination unless they specify otherwise, whereas the general group of participants in this project were invited to contribute to presentations, peer-reviewed articles, and general knowledge sharing if they wish and be listed as co-authors.

Conceptualizing Etuaptmumk

As mentioned above, Etuaptmumk was used as a **guiding principle and theoretical consideration** for this study. In this study, drawing on the strengths of the OT profession mentioned above (challenge to the biomedical model, its holistic view of the client, client-centred practice, the consideration of spirituality in the context of wellbeing) and keeping Indigenous worldviews and Indigenous epistemologies at the forefront was a necessity. I envisioned being able to offer concrete knowledge that is new, innovative, and can push the profession past solely focusing on Euro-Western perspectives, values, and ideologies towards a profession that truly lives up to the written commitment towards equity, diversity, inclusion, and in turn, reconciliation. In order to do this, there is a need for the profession to be open to doing significant restructuring, from the ground up. The profession has clearly stated commitment to this work and must now take seriously the advice generated and work already being done by Indigenous OTs.

Further, I envisioned documenting how Indigenous OTs may already be enacting Etuaptmumk principles (even if they do not use that term). At the onset of this work, I anticipated that numerous OTs have drawn strengths from the Western underpinnings of the profession while also utilizing Indigenous knowledge to better support the clients they work with. Documenting these instances, as well as the tensions experienced by participants, will ideally offer valuable insight into concrete ways that Indigenous OTs are already doing the preliminary work on behalf of the profession by using their own values and worldview to better support diverse clients.

In the next four chapters I lay out the results of this research. First experiences in occupational therapy education, then experiences in employment. The following chapter

explores building community, and Chapter 7 examines guidance for advancing an Indigenous OT community of practice. Participants have been numbered from OT1-OT13 to protect their identities and quotes are assigned to each participant using their assigned number.

CHAPTER 4: EDUCATIONAL EXPERIENCES IN CANADIAN OCCUPATIONAL THERAPY PROGRAMS

This chapter examines the educational experiences of licensed occupational therapists who participated in this study. These experiences span many years – with some participants graduating over 15 years ago, whereas others have just recently graduated their occupational therapy training. The similarities among experiences, spanning across many years, highlights their observations about the lack of progress the OT profession has made to date to better support Indigenous learners and urges better practices moving forward.

It is important to note that throughout this chapter and subsequent ones, I will be using the term 'they', 'we' and 'us' interchangeably; to highlight and pay respect to the fact that I am a participant in this research and share many (but not all) experiences with those who participated in my research.

These themes are organized to tell a story – beginning with why Indigenous OTs got into the profession and the value they saw in it. Immediately following will be an exploration of their experiences within the program. This chapter will continue by contextualizing these experiences with the main theme that emerged; "one way of knowing" which critiques the profession's underpinnings and assumptions, and how those impact Indigenous OT student experiences. Finally, this chapter closes by highlighting how Indigenous learners describes ways they cope in occupational therapy spaces, illuminating the often-invisible work that goes into belonging, surviving, and thriving in colonial spaces.

Beginning a journey into occupational therapy

Indigenous occupational therapy students spoke at length about what drew them to the profession in the first place. Many reflected on why they chose Occupational Therapy as a health profession. OT12 always knew they wanted to do something health care related, and listed medicine and physiotherapy as choices prior to OT. Others similarly reflected on the fact that OT was not necessarily on that list and reflected on the notion of it being a relatively unknown health profession. OT1, who didn't know a lot about OT before applying, nonetheless felt that occupational therapy was a "happy medium in health care" noting that occupational therapists often aren't required to work long hours, which gives more flexibility. OT2 similarly noted that they found the profession to be less formalized when compared to other health professions, providing the opportunity to "have a great time" and work "from the heart". OT11 shared the following about her decision to get into health care:

> "…it's a privilege to see people at their most vulnerable. …When I was in acute care, people in the hospital don't really have— Left to their own devices, they'd maybe choose to be healthy, and not have to see me right now, at all. And so, the fact that I'm here, when they're in their hospital gown, you know, there's so much vulnerability, that they aren't really choosing to have but it's just they're, it's forced. I've just seen so many people be in that position and be so kind, and, have so much power taken away from them, in that setting. I've had a wonderful opportunity to learn, how to *be*, you know, from a very young age. So, and to see what happens, unfortunately, when people don't have as much empathy or

> whatever, and, to see what happens if people are not kind, in a position of powerlessness, how care is negatively – like, their care is impacted if you're going to be roll[ing] your eyes, and [having people] warn you. And it's, it's so silly. I always go in with the same approach and treat them with respect and kindness and I've never had a problem with people. . .All the ones I've been warned about, I've never had a problem."

This reflection on the privilege of being a health care provider resonates with other reflections from Indigenous OTs, sharing their hopes for being able to provide important, accessible, and relevant care to all. These reflections and experiences are deeply embedded in a system that continues to disrespect and discriminate against Indigenous Peoples, both accessing and providing services.

Interestingly, some participants shared their push into occupational therapy by sharing what they knew they *didn't* want to do; OT8 shared that they always had an interest in health care, but felt physiotherapy "wasn't holistic enough for me" and OT5 noted that they narrowed down their interest by eliminating professions like social work, which they said "hit too close to home" for them in relation to family and their upbringing. OT11 shared stories of her brother and father going through post-secondary education and knew she was not going to be interested in the scientific disciplines they pursued though post-secondary education was a typical trajectory in her family history. She described the decision to pursue something else by saying "Science? I just don't, I can't fathom" and went on to talk about her path into a social sciences degree before applying to OT.

Others got interested in becoming occupational therapists by having been exposed to what occupational therapists do earlier in their lives. OT4 shared that they got interested in occupational therapy as a recipient of OT services when they were in their early twenties. Others reflected on the impacts of seeing someone close to them receiving support from an occupational therapist as a key factor in their decision to pursue the career. OT8 shared that growing up her family had numerous health incidents that resulted in the need for occupational therapy services. This resulted in her seeing what occupational therapists do and continuing to do some of that work for family members. She stated, "I was already kind of being an OT to her [grandmother]" when asked about her motivation to pursue occupational therapy. OT10 similarly reflected on observing a family member receiving OT services, and when asked what drew her to the profession, she stated that: "OT wasn't strictly from a medical model. It incorporated other models, and the intersectionality piece."

Finally, OT11 shared that her father suggested she go into OT; he likely was aware of the profession due to being a social worker, and her mom was similarly involved in the health and social service professions. Similarly, OT13 began considering OT when a family friend had a daughter who was an OT, encouraging them to go for a career in the profession. Participants all had unique ways of becoming aware of what occupational therapy is and what OTs do, however many came upon the profession and its possibilities through personal experience or through their relationships with others who had involvement with OTs.

Numerous participants reflected on the fact that occupational therapy seemed to match, at least in some ways, with their own core values. OT8 stated that she felt OT fit well with an Indigenous perspective, and this theme was echoed by OT7 who noted she "loved how holistic it [OT] was". OT5 and OT6 had similar thoughts, in that they felt OT resonated with them and matched their core values. OT5 brought forward the idea of the medicine wheel, and how they felt occupational therapy could be a profession that considers all directions of health and wellbeing for an individual and/or collective.

All Indigenous OTs in this study, having completed their OT degrees, found ways to draw on their strengths. They actively worked to integrate Indigenous identities into their professional work as they embarked on their educational journeys.

Attending occupational therapy programs

The Indigenous OTs in this study spoke at length about their experiences attending OT school. Participants attended programs across the country and important similarities emerged in their stories. Although there were a mix of experiences, the overwhelming majority of participants shared at least one story of discrimination, alienation and isolation as an Indigenous learner in these learning spaces.

First, key general experiences will be discussed through the creation of a short narrative. This story was created using information from the individual stories collected and is shared in this way to avoid identification of any one individual. This narrative highlights the fact that Indigenous OT students are continually challenged and questioned in systems that do not meet their needs. It also fills the gap left when we break down stories into themes, as the themes do not capture cumulative, lived

experiences in their entirety. Further, by sharing this concrete example of the commonalities across experiences, I hope to move past the continual questioning that is often a dominant response when one-off incidents of discrimination and racism emerge and are shared. There are patterns present that illuminate important lessons for all, regarding how we can move forward to better support Indigenous OT students in these spaces. This story captures some of the daily, cumulative experiences of Indigenous OTs in this study, providing important context and grounding, and aims to capture the holistic nature of these impacts on participants.

Coming towards the end of my undergraduate degree, I wasn't entirely sure what I wanted to do after. I had come to think about applying to occupational therapy when someone in my family needed occupational therapy services, and it seemed like a really cool profession to be involved in. I was fairly sure I wanted to get into health care but wasn't crazy about the idea of the long shifts and being away from family so much. I figured occupational therapy would allow me to have a somewhat regular work schedule which allows for a better work-life balance. But, before I could apply, I had to take a few courses to get my GPA up. I had a lot of personal and family things going on in my undergrad that took me away from school, and lowered my GPA, but was hopeful I could make it work.

Fast forward to the following year, I managed to bring my GPA up and finish the prereqs required for the OT program, so I applied. I'm asked to self-identify, which I do – but I also wondered.. did I get into the program <u>because</u> of this? How could they support me as an Indigenous student? I waited….and got in! I was excited to start something new,

but also realized this meant I had to stay physically at university, which was away from my community. The distance from my support system would be difficult, but I knew at the time that this was only temporary and I would be able to bring back my knowledge and expertise to my community and other Indigenous Peoples.

I began the OT program and quickly realized that I was the only Indigenous student in my class. I browsed through the list of faculty members as I was starting to get more familiar with the program, and also quickly realized that there were no Indigenous Instructors or Professors in the school either. In my undergraduate degree, this wasn't really something I thought a lot about, because I took a lot of Indigenous specific courses taught by Indigenous people. I was worried – but continued to put my head down and tried to get used to this new, and busy, program. The first semester was a whirlwind, and I didn't have much time to get to know people between the long school hours and having to work in the evenings and on the weekends.

I managed to survive my first semester and was excited to take a break and go home to rejuvenate my soul. Because we didn't have any Indigenous representation in my class, I felt a bit isolated. I spent time learning about what Indigenous resources were available on campus and sought them out in my own time – the school didn't really share this information with students directly. I also heard classmates making stereotypical and harmful comments about Indigenous Peoples, but I just didn't have the energy to speak up and fight in this moment. I was just trying to survive. I did come back to school feeling better, healthier, and supported to challenge some of the comments being made. As the only Indigenous person in the room, I felt a sense of obligation to do so.

Returning for the Winter semester, everything was much the same. As I started to learn about what OT is and what OTs can offer, I started to wonder if I truly belonged in this profession. I was hoping to learn about all the great ways I could work with my community and address really important health concerns, but I spent a lot of time learning about models, theories, and assessments that didn't really resonate with the way I saw the world and was brought up. I brought this up occasionally in class, shared my perspectives, and was praised for my critical eye – but nothing changed. One time, the school brought an Elder in to share knowledge with us, and I was excited to finally get to connect with another Indigenous person. Although I was grateful for that experience, I felt as the only Indigenous person in the room, a lot of people looked at me to be the leader of this learning opportunity alongside the Elder. We went around in a talking circle format, and I spoke to the trauma that Indigenous Peoples have endured. I was met with the comment "well, all people experience trauma, not just Indigenous Peoples". The instructor ended the discussion quickly after, with no follow up or debrief. I reflected on this incident, and felt like my classmates, my instructor, and my school didn't understand our experiences as Indigenous Peoples at all. I questioned whether this degree will truly help me become the healthcare provider I wanted to be, and thought about quitting, frequently. This all came to a head when I started my clinical placement at the end of my first year.

I specifically asked for and was given a placement working with Indigenous communities. I was excited to finally be able to do the work I wanted to. But…this experience turned out to be one of the most traumatic for me throughout my OT degree. I

felt like I was walking on eggshells the whole time during this placement because I had a white preceptor who did not seem to understand me, nor how I thought about OT working with communities. I offered tobacco as I entered the community as is the protocol I was taught when asking for knowledge to be shared. This got me in trouble. My preceptor accused me of bribing clients and told me I could lose my license if I did that once I graduate. Although my preceptor had worked with communities for a while, I didn't feel as though she made any consideration or change to the way OT is practiced for the context that she was working in. She also didn't seem to value or appreciate my opinions as an Indigenous person. I was so scared to be penalized for everything that I did that I ended up not bringing my whole self to my work. Her tone of voice and demeanour told me all I needed to about belonging in this space. I always felt torn between what I knew I needed to do for the person in front of me, in keeping with my community knowledge, but I also knew it would not sit well with my preceptor. I started to second guess everything I knew and understood, trying to silence my own instincts. I ended up failing. I wasn't sure at the time how to approach this given that our school spoke about how hard it was to find preceptors in the first place, and preceptors volunteer for these roles. Was getting another preceptor even an option? I felt like no, it wasn't.

I brought up my concerns about this situation to my school. I was told I could file a report against her and try to fight the grade, but then was told I should not talk about this situation with others and I should keep it to myself. Keep it to myself? I thought at the time, how am I supposed to navigate this situation alone? I wondered, are there other Indigenous OT students going through the same thing? Who knows – but in that moment,

I felt alone. Isolated. Exhausted. I didn't pursue action against my preceptor in fear of not having support for my action from other faculty and administration at the university. I ended up having to redo my placement but could not continue into my second-year courses until I had done so. Luckily, I didn't have to sit out for a full year and just filled my 'off' time with redoing this placement. So, I spent the summer trying to make this up, while still feeling like I was walking on eggshells. I did get it done, but it's not work that I was proud of, or that I felt represents me or my potential.

Right at the beginning of my second year, first semester, I had a family crisis that took me away from school for two weeks as I had to return to my community. I met with someone from the school to talk about my situation, and it honestly came across more as an inconvenience for them. Their "I'm sorry this is happening" seemed less than sincere. It felt like, rather than trying to help accommodate me and support me through this time, the school was actively trying to make it harder for me to complete this degree. They talked about fairness to other students, and program expectations, but never asked if I was okay or how I was coping with what I was going through. I went home, albeit reluctantly, worried about failing, but knowing I needed to do this and to support my family during this time. I talked to friends and family about this while I was home and they reassured me that my heart is in the right place, I was doing the right thing, and to continue with their support.

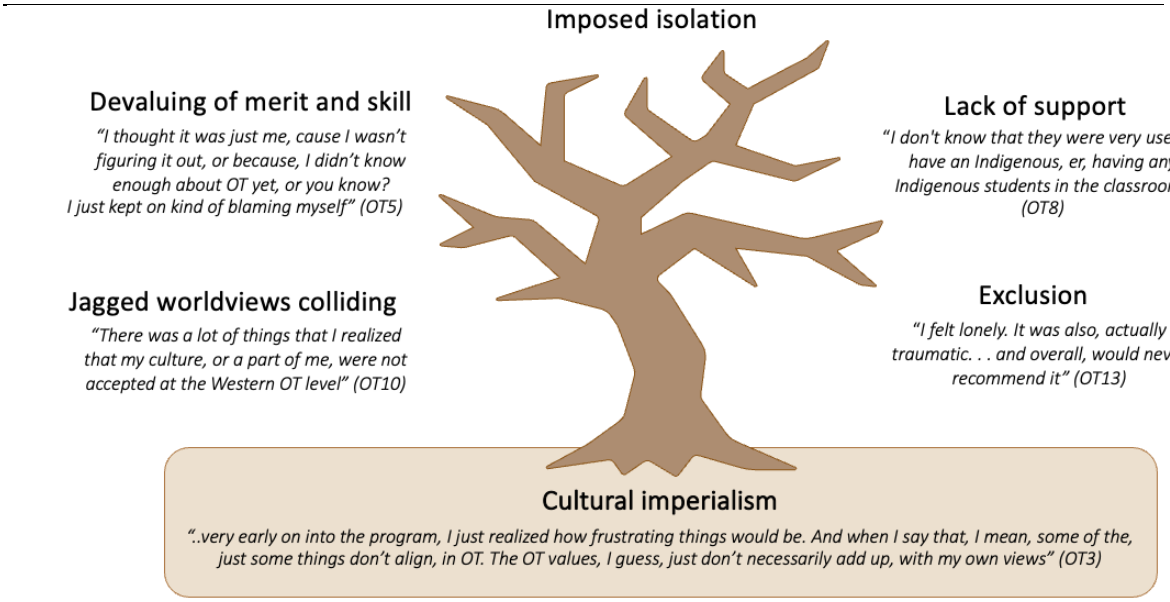
I did continue on. I felt as though I was finally catching up and getting my feet under me after having to take a few weeks off, and then I experienced some really upsetting situations of racism in class and on some placements. I again brought my

concerns to the school after a lot of time thinking about whether voicing this concern would benefit me or be detrimental to me and am met with the question "what do you think we should do about it?". I have to say, this time was mostly a blur for me, because I found it near impossible to focus on my OT program (which was intense) while I was in the midst of this turmoil I was experiencing. The fear of retaliation was paralyzing. In that moment I sat in silence thinking, isn't that your job to figure out? I'm coming to you! I left this meeting with no real solution or recourse for my experiences, feeling more alone than ever. I felt like I've endured so much already, and it would be a shame to quit now, so I again put my head down and tried to survive this degree with the hopes of doing the work I set out to do.

Coming out the end of my degree – when people asked me how my OT school experience was, the word that comes to mind is 'traumatic'. I did not feel supported as an Indigenous learner and did not see myself or my own values reflected back to me at all in my degree. The supports that nourished me and got me through my degree were ones that I sought out myself. I felt very alone in my cohort. I wondered why targeted recruitment of Indigenous students is happening if there are no mechanisms on the other end to better support us. I was, and still am, hesitant when other Indigenous youth come to me asking me about my profession, I am ashamed. How can I recommend and try to recruit more Indigenous Peoples into this profession when my experience has been so negative?

This story encapsulates numerous experiences put together, to paint a fulsome picture of Indigenous OT student experiences in Canadian OT programs. What follows is

the presentation of subthemes that emerged from my data collection in relation to attending occupational therapy programs as an Indigenous student. First, I present a visual of a tree to help contextualize the organization of themes presented below, with the underlying key issue being that occupational therapy imposes *one way of knowing; named cultural imperialism.*



Imposed isolation

Indigenous student representation. Indigenous occupational therapists talked at length about being the only one or one of few Indigenous students in their class. This lack of Indigenous representation was discussed by every participant in this research. OT1 noted that they didn't even get to know if there were other Indigenous students in their cohort as it was never discussed. They questioned the goal of self-identification if ensuring that Indigenous learners are well supported is not at the front and centre of affirmative action policies. OT6 and OT12 also shared they were the only Indigenous students in their classes, while OT3 noted that they "just assumed they would be the only

ones there" and OT8 shared how hard it was to be the only First Nations person in the entire class. This imposed isolation eroded any sense of belonging.

In contrast, some Indigenous OT students did have others in their cohorts. OT4 highlighted that there were two other Indigenous students in their cohort, although one of them ended up dropping out. OT7 noted that there was one other Métis individual in their cohort, but they did not have a lot of time to be able to build that relationship given the rigour of the program. This resulted in them keeping their identity to themselves, which was a possibility due to being white-presenting. Similarly, OT10 acknowledged there was another Indigenous student in their class but noted that "we didn't really click". This is an important point to make – given the diversity of Indigenous Nations, one cannot expect to be friends with and get along with all other Indigenous Peoples. Yet, pan-Indigenous rhetoric often leads to this assumption that all Indigenous Peoples are similar, share the same values, and must get along.

Participants reflected on what it meant being the only one or one of few, highlighting the sense of responsibility that places upon them. In reflecting on an activity where students were asked to disclose their identities, OT2 commented:

> "..but it turns out I was the only one in this group that actually put their hand up ... it didn't impact my, I want to say it didn't impact my relationships, but it definitely impacted my sense of maybe, my sense of, that I was holding the importance of Indigenous health on my shoulders in my class."

This sentiment was echoed by OT8, who shared that, "I don't know that they were very used to have an Indigenous, er, having any Indigenous students in the classroom". This

resulted in feelings of being Othered and illuminated who is the 'expected' OT student in these spaces, and inadvertently who belongs in these same spaces.

Lack of Indigenous instructors. Beyond isolation with their classmates, participants also reflected on the demographics of instructors and guest speakers in their OT schooling. OT12 couldn't recall any Indigenous faculty specifically, whereas OT5 stated that they, "Didn't have teachers who were from different walks of life," illuminating the idea that most teachers came from a very particular background or worldview. This point is echoed by OT6 who shared that they felt all faculty were from "a certain demographic" and subsequently did not see themselves in their professors. Similarly, OT8, who graduated only 3 years ago, criticized the lack of Indigenous instructors within the entire school. When there were instructors from diverse backgrounds, OT3 noted that "they [white students] were not very nice to them". This latter point is a major barrier to meaningfully valuing and utilizing Indigenous knowledges in the OT profession as well as aiming to recruit Indigenous scholars to fill these gaps because those who bring diversity or other ways of doing things are at times overtly mistreated.

OT student demographics. Without Indigenous classmates or instructors, Indigenous students felt different, isolated, and underappreciated in OT school, surrounded by white settler people and worldviews. This is compounded by the fact that the overwhelming majority of OT students come from non-Indigenous backgrounds and experiences. OT3, when reflecting on the demographic make-up of their cohort, shared that "they're all predominately white, white upper class, like you know, higher, you know,

came up from very privileged backgrounds, of course". This point was echoed numerous times, including by OT10 who stated that they had a hard time relating to their classmates because "probably ninety nine percent of my class, a lot of them were white" and OT7 who stated that the majority of their class was of white or immigrant descent. It's important to note that OT3, OT7, and OT10 all graduated from OT school within the last 5 years and represent more than one OT school program, highlighting that lack of diversity is still an ongoing issue in OT programs despite calls for diversity, equity, and inclusion.

This lack of diverse representation in the student body, coupled with few Indigenous students and virtually no Indigenous instructors, seriously undermined feelings of belonging for participants. OT3 shared that "…it's pretty early into OT, I guess OT school, where I just thought 'Okay, I'm just, this is not for me'". Others reflected on how this impacted their sense of belonging, such as OT4 who felt they did not see themselves represented very much in their OT education; OT10 who noted they felt very isolated as "one of the only dark-skinned people in the class"; OT1 who shared that almost their entire cohort was white; and OT5 who blamed themselves for not being able to figure out information in their program: "I thought it was just me, 'cause I wasn't figuring it out, or because like, I didn't know enough about OT yet, or you know? Like, I just kept on kind of blaming myself." This point surrounding a lack of other ways of knowing, being, and doing in the OT profession will be taken up in more depth later, in the major subtheme "*one way of knowing*", which is also referred to at times as cultural imperialism or epistemic racism.

Classism in OT. An important subtheme of *OT student demographics* emerged from the discussion of the 'typical' make up of OT student cohorts. Both OT8 and OT1 noted the economic differences among them and their peers, with OT1 stating that many of their classmates came from wealthy backgrounds and didn't really have to work, while she was working almost full time throughout OT school as she grew up in a household with limited finances. OT5 had a similar experience, noting that they "barely had enough to survive" and reflecting on the fact that their parents did not have the financial resources to support them at all throughout school, stating that they had "no safety net" when it came to finances. This point is furthered by OT8 who linked this to the lack of understanding of Indigenous Peoples: "A lot of them [classmates] were extremely privileged, extremely wealthy…They didn't have a care in the world for Indigenous people."

OT5 and OT6 reflected similarity on the makeup of their OT cohorts, with OT6 using the term "elitist" and OT5 noting that the student demographic was "predominantly white, middle to upper class, females, cis gendered females". Interestingly, OT5 graduated roughly 15 years ago, while OT6, OT1, and OT8 all graduated within the last 4 years, and they came from 3 different OT programs, pointing to little change in the make-up of the profession's educational programs.

Cultural imperialism

Amidst the experiences discussed above regarding the lack of diversity in OT programs, it becomes apparent that the *expected* or *typical* OT student mirrors the norms of the Euro-Western population on Turtle Island. That, in combination with the

historical underpinnings of the OT profession, creates conditions that lead to the core theme that emerged concerning the educational experiences of Indigenous OTs, which has been titled cultural imperialism. This means that OT is derived from and continues to impose one way of knowing, grounded in Western settler-colonial worldviews, which renders all other ways of knowing invisible, invalid, or lesser.

Every single OT who participated in this study noted the cultural imperialism of the profession in one way or another. When reflecting on what knowledge is privileged in the profession, OT12 had noted its Western roots, and said, “I mean, and that makes sense. It [the profession] was created by a bunch of white ladies.” OT2 similarly stated that, “Everything we do is sadly really built from that [Western perspective],” and OT1 continued this point by saying that, “This is the way that it is, and there is no other way to do things” repeating the message they got in learning about OT. When reflecting on what exposure they got to working with diverse populations, OT11 shared a story about cultural safety, which she reflects was more about cultural competence rather than principles of cultural safety, in that it emphasized learning cultural traits and practices rather than recognizing power relations. She went on to say: “Honest to goodness, what we learned about was like, if your patient is Ukrainian, learn about making perogies and babushkas and stuff. I was like, 'This is so stereotypical. This is– what?' So, I remember learning that and kind of cringing.”

Not only were the Indigenous OT students having to learn and adapt to a cultural worldview that was implicit yet infused everything about the profession, they also found

that worldview clashed with their own. OT3 reflected on the clash between their personal values and the values of the profession they were being taught:

> "Very early on into the program, I just realized how frustrating things would be. And when I say that, I mean, some of the, just some things don't align, like in OT. Like the OT values, I guess, just don't necessarily add up, with my own views."

OT4 also shared these sentiments, highlighting the "individualistic" nature of Western paradigms of health and illuminating a gap between the way they grew up and the expectations placed on them as a clinician to work from a particular lens. The Indigenous OTs recognized that the way the profession is set up is "very good for a particular population" (OT6), that it is "based on, largely non-Indigenous people and notions" (OT7), and that it is "supporting the machine to keep running, like capitalism" (OT12) in relation to how OT is structured. Yet there was little recognition or acknowledgement that the profession is steeped in colonial cultural perspectives. This led to a major gap becoming apparent in the education provided to OT students: "They didn't really talk about how different cultures or different ways of being brought up impacted your own understandings of OT, which is where I think I really struggled" (OT1).

Other Indigenous OTs also reflected on how this 'one way of knowing' impacted their experiences in the program. For example, it meant their own knowledge and life experiences had no place in their education programs: "I had a shit ton of life experience, but I was trying to hide it, because it wasn't valued knowledge, or valued information" (OT5). OT6 emphasized the expectation that students adapt to what they were being taught, when they do not meet the expected norms in the profession. The lack of

recognition that OT ways of knowing were culture-bound, and a colonial imposition, made learning some of the material more challenging. For example, participants shared their difficulties grasping OT theories, saying they didn't feel they knew what teachers were asking of them. OT12 recalled always questioning, "How is this relevant for me?" when reflecting back on what they learned in OT school. OT1 suggested the regulatory aspects of the profession intensify the notion that there is only one right way to know, be, think and do: "Occupational therapy in particular is super regulated. You learn things, you learn processes, and it's from point A to point B, there's not really a lot of deviation from that."

This lack of deviation or consideration for diversity impacted virtually every aspect of participants' OT school experiences. When asked about key features of the profession that they felt were problematic or not in line with their personal ways of knowing, OT6 reflected on the ways in which the profession categorizes everything into discreet elements, such as separating life into categories (e.g., self-care, productivity and leisure) and how this is not representative of their Indigenous way of seeing the world. OT8 provided a concrete example of this when reflecting on the notion of client-centeredness, a core principle of OT: "It wasn't— You know, 'Oh, it's client centred. Your grandma's the only person that gets to make the decision.' It was like my grandma, as an Indigenous person, values the opinion of our whole family."

Further, some OTs talked specifically about how the Western lens of the profession impacted their ability to succeed on fieldwork placements. OT5 used the term "cookie cutter" to describe their placement options, indicating they were all the same.

OT3 noted that the clinical instructor they were assigned to for one placement was “very colonial” in their practicing and thinking. This instructor also perpetuated negative stereotypes about certain clients, particularly those on social assistance or welfare. Once the instructor, when knocking on the door of a client’s home, stated, “They’re probably not answering because I look like a cop” in a joking manner, to which OT3 responded, “Well, of course, that’s fair.” A similar experience was shared by OT4 who was placed with a clinical instructor who was overtly racist against Indigenous people. The instructor asked OT4 to reflect on “assumptions we could make about that,” in relation to seeing an Indigenous client, then motioned as if the client were drinking a bottle of booze, and then laughed.

In reflecting on one clinical placement, OT10 recalled, “my educator was basically not very accommodating to, or open to, or understanding of different cultural ways of doing things.” They went on to say:

> “By that, I mean, in our culture, we're not very, um, the way we talk to each other, you know, how we have to go in and openly be like, 'Oh hi, how are you?' Like, sometimes, it takes us longer.”

OT10 was penalized for time they spent getting to know a client, and also penalized for not making adequate eye contact. Their instructor stated that they needed to have, “better eye contact for working with clients.” This lack of understanding of cultural differences by the clinical instructor had grave consequences for this OT, who did not even notice this was an issue, and felt that, “It was really, really traumatizing for me, because it was, it was just so hard.” Judging Indigenous OTs solely on Western standards

and expectations sets them up for failure and leaves them torn between enacting their own cultural knowledge and values or enacting Western colonial knowledge and values, which are not recognized as such, but rather positioned as neutral, universal and professional.

Finally, a few OTs reflected on their upbringing and how that impacted their ability to succeed in a program grounded in Western ideologies. OT6 shared how they grew up removed from their community, and acknowledged that growing up with Western influences did help them to get through their OT schooling. OT1 similarly commented, "I probably teeter in both worlds more easily than someone, you know, who grew up in community or someone who grew up from, you know, solely a traditional way of knowing." The profession being grounded in, teaching from, and imposing a singular (colonial) way of knowing left most Indigenous OTs feeling like they were having to *be* in two worlds, which is the following theme presented. To capture the experiences narrated I borrow the title of the theme, 'jagged worldviews colliding' from Leroy Little Bear (2000).

Jagged worldviews colliding

This reflection brought forward by Indigenous OTs captures what they felt they had to do to succeed in OT programs, but the theme also pertains to post-secondary education broadly as well, which continues to privilege and operate from a Western lens. Both OT1 and OT2 emphasized the need to operate at the intersection of two cultures to survive OT education. OT2, who is of mixed ancestry, shared that they felt they were "kind of being stuck in the middle where you have your colonizer roots, but you also have

your Indigenous roots, but you don't quite fit into either one of them." This sentiment is shared by OT7 who stated that they never felt like they were completely living the traditional way of living, nor did they feel entirely like someone who was white, which left them feeling "caught between two worlds".

When considering the relationship between OT and Indigenous knowledges, OT4 shared they felt that OT was entirely separate from Indigenous paradigms; this would leave someone in one world or the other, but not both simultaneously. OT10 similarly reflected that in her education journey, "There was a lot of things that I realized that my culture, or a part of me, were not accepted at the Western OT level". OT13 pondered the teacher/student relationship in their culture and how sacred it is and must be treated as such. She recognized that in OT programs, this relationship is not seen in the same way, which has grave impacts on the outcomes of those relationships. OT5, in trying to navigate between two worldviews, quickly realized that mainstream systems themselves are simply not working for Indigenous Peoples. She described it as oppressive and shared the term 'institutional trauma' to describe the demand that she assimilate into the Western ideals of the profession.

This torn between two worlds experience left Indigenous OTs feeling alienated in their programs. They were very clear that the two worlds they lived were not valued equally in OT school, rather Western colonial norms and rules were held out as universal. OT10 noted the lack of fairness when she was held to solely a Western standard, saying, "They [OT Instructors] said I wasn't very good at communicating. But, it's just that I wasn't very good at communicating with using a Western standard." Further, OT1 and

OT13 reflected on the personal crises they both experienced in OT school relating to family and community dynamics, with OT13 describing it as "constant crisis." They both felt this aspect of their lives made it difficult to be a full-time student in a rigid professional program that had a general lack of understanding of Indigenous Peoples' history and present-day experiences, and the ways those give rise to the central importance of family, community and connections.

The expectation that Indigenous OT students must assimilate, must leave their ways of knowing, being, and doing at the door when they enter OT programs, is highly problematic and does a disservice to them as unique and skilled individuals. It also does harm to the profession, which could greatly benefit from seeing, recognizing, and valuing diverse ways of doing. Nonetheless, OT5 raised an important reminder about ensuring we maintain our values in these spaces and use our knowledge for the betterment of our People: "The reason that I'm good at what I do is because I still live it. I still live it. I still get it."

Requiring Indigenous OT learners to teeter back and forth between their own worldview and the worldviews espoused by the profession has consequences. Below are themes that emerged as outcomes of the profession operating through the imposition of one (dominant) way of knowing; they include exclusion, questioning of merit and skills, and subsequently a lack of support.

Exclusion

If the profession operates from, and privileges, one particular lens, it asks that others from diverse ways of knowing change or assimilate to fit into a space where they

do not see themselves reflected back. As one can imagine, this has consequences which have personal, interpersonal as well as health impacts. During the storytelling sessions, Indigenous OTs were directly asked about whether they felt like they belonged in OT school. Most simply did not.

When asked specifically about belonging in their OT program, OT13 quickly stated, “No. Hell no.” OT12 said, “Right from the get-go. . . I didn’t think I really belonged there.” OT1 and OT3 shared similar sentiments in the way that profession and educational programs are structured made them feel as though they did not belong. OT6 highlighted a particular dilemma that Indigenous OT students face by highlighting that they did not see themselves reflected back in things like textbooks during their OT training. At the same time, OT3 said that they didn’t feel like they particularly belonged, yet also said, “But that’s all right,” emphasizing that they did get through the program and are now practicing as an OT. OT11 shared the following story about seriously considering leaving the program along with another student, who had already made the decision to do so:

> “I just remember, there was a girl who quit in the first week, because she's like, 'Oh, this is not for me.' And I remember having this, like, huge conversation with her, outside the course, the school. We were outside the building, and it's like 'You know, I completely agree. This is horrible. I want to get out of here. I'm jealous.' But I just, I can't do that. If I start it, I'll just finish it.”

Although OT11 ended up staying in the program, she is not the only OT who thought about leaving OT education. This sentiment was also brought up by OT10, OT12, and

OT13, with OT13 going on to say that they felt "a lot of isolation" and "felt like shit in every OT class". She emphasized how the lack of belonging and safe space for Indigenous learners impacted her ability to be well: "I felt lonely. It was also, like, could be, like, actually traumatic. . . and overall, would never recommend it."

Loneliness, often due to being highly isolated in their schools, deeply impacted Indigenous OTs' sense of belonging in their educational programs. Some reflected on the actions they took to enhance their feelings of belonging. For example, OT5 spent some time in their educational journey "trying to fit in, trying to blend in," and shared how difficult that was for them. Others similarly talked about the ways in which they went about trying to belong, such as OT8 who shared: "I kind of talk myself up and I tell myself that I belong. You know?" Going into community – "That helped me feel like I belonged because I knew those people, right?"

Interestingly, the notion of belonging is heavily dependent on those we surround ourselves with, what we share about ourselves, and the degree to which we have control over identity disclosures. OT6 felt like they did belong in outward ways at times but noted that selective disclosure of their Indigenous identity played a big factor in that. The ability to selectively disclose plays at least a part in belonging, as OT2 also reflected on: "I felt like inside, I stood out, but outside, I kind of just blended with everyone else," alluding to a kind of internal debate that Indigenous OTs may go through if they outwardly are white-presenting. OT13, in reflecting on where they are now, feels as though they do belong in the profession as they have carved out a space for themselves as an independent OT practitioner, working directly with Indigenous communities. A powerful

quote from OT5 describes her journey to belonging as an OT: "I'm way better as an OT who's challenging the system, than I am as an OT belonging in the system…Because there is no challenging when I'm just trying to conform and fit in."

These reflections on belonging highlight the ways in which our health professional education systems perpetuate a particular norm or image of the 'expected learner.' In the context of recruiting more Indigenous students, we must consider how belonging is framed in predominantly Euro-Western spaces and the impacts that has on Indigenous students. Some OT programs, like many other health professions programs, now have affirmative action policies, with designated seats for Indigenous learners. It is in the context of such policies that the following theme of questioning of merit and skills emerges.

Devaluing of merit and skills

Prior to providing an overview of this theme, it is important to contextualize this devaluing of merit and skills by linking it to the colonial, Western ideologies that are embedded in, and guide, health professional programs. Because Indigenous learners are being heavily recruited into post-secondary spaces, and in particular, health professional programs – affirmative action policies and designated seats for Indigenous learners at times result in backlash from other, mainly White, students as well as faculty. The devaluing, and in turn questioning, of merit and skills in relation to getting into OT school must be understood in the context of the continued lack of appreciation, or underappreciation, shown for Indigenous students and the unique knowledges and experiences they bring to the OT profession.

At the time that OT1 and OT2 applied to OT school, there was a commitment in place to recruit more Indigenous students. OT2 noted that they felt 'lucky' to be accepted first try, whereas OT1 reflected on whether they got into OT solely because of their Indigeneity, or whether it had to do with the hard work they had put in. These sentiments alone allude to a questioning of their own place in these programs, which OT7 laid out nicely when they asked, "Is it my competence level or is it because of what I look like?" that led to their admission into the OT program.

This uncertainty about the basis for admission led some participants to question whether they were good enough. OT12 reflected on this by sharing the following in relation to belonging in OT school:

> "Just kind of like, 'Okay. I'm obviously the weirdo here because this is – You know what I mean? I put it on myself, that it's like 'Oh wow. I'm not good enough' or 'I don't belong in these spaces and I have to change the way that I am, in order to – ' cause everyone else seems to be, like – they get along great, and they seem to enjoy themselves and they like, have all these friends and people."

This kind of institutionally-structured self-doubt, meaning that the institutional structures, policies, procedures, and resulting stereotypes that people uphold could be terribly undermining – resulting in self-doubt in Indigenous students.

Interestingly, some participants attended OT schools at a time when Indigenous recruitment was less prevalent in the health professions. OT5 questioned whether she would have gotten into OT after it moved from a Bachelors to a Masters program, despite having years of lived experience to bring to the table. She emphasized that she

felt forced to downplay her differences: “tried to sound as white as I could, as normal as I could.” This is a particularly powerful quote showing that Indigenous OTs understand deeply that they must ‘play the game’ to get into particular spaces. This came up in OT10’s storytelling session as well, a participant who is a recent graduate of an OT program. They described having to “fake it to make it” and get through. This idea of *faking it*, again alludes to a questioning of their own value or place in OT in relation to what they have to offer the profession. OT11 speaks to this point when they share how they’ve internalized some of their negative experiences:

> “I feel like people have said all kinds of racist stuff around me, assuming I'm just, I don't know, maybe they just don't care. I've felt invisible many times. And so that's been painful. Like I just really internalized all my failures for a long time of systemic racism and micro aggressions, and just dealing with all the stuff.”

Finally, OT6 noted that they felt that “there’s been opportunities that I don’t always feel like I deserve.” They went on to qualify this statement, by contextualizing this thought: “But that’s partly because of that lack of sense of belonging with that identity.”

This theme did not entirely resonate with all of the Indigenous OTs, suggesting that strong cultural connections may act as a buffer. For example, during the Stage 2 sharing circle gathering with Indigenous OTs held in 2022, some felt that they did have strong grounding in their traditional Indigenous values and realized that they were trying to place their unique skills and knowledge into a box where they did not fit. This meant that they did not necessarily feel they ever questioned their own value or right to be

where they were – but rather were unsure if this was the best place for them. Most Indigenous OTs who felt this way had strong cultural and community connections.

Importantly, this questioning of one's worth, merit and skills, which was prevalent for many Indigenous OTs in this study, relates directly to the assumptions and norms perpetuated by colonial education systems. How can we see value in our skills and knowledge when we are continually told that what we bring to the table is less valuable, or even irrelevant, to OT? This questioning of skill and merit is closely related to the lack of support Indigenous OT students received in their educational journeys.

Lack of support

Most – but not all – Indigenous OTs noted a serious lack of support in their respective programs. This began right at the onset of starting their program, asOT1 shared: "I self-identified, but nothing really came out of it; I don't actually know if there were any other Indigenous students in my class." She followed this point up with a simple solution: "It would have been nice to get like an email from someone saying like, "Hey, I know you self-identified, do you have any interest in meeting other Indigenous students?" OT13 similarly felt the lack of support early on in their OT program, comparing it to her undergraduate degree and saying she felt, "significantly less support" in OT. Interestingly, she continued by sharing that it is the relationship-building piece that she felt was lacking in her OT schooling – which is at odds with much of what the profession boasts about as core values. This lack of relationality was also prevalent for OT5, who said she didn't feel as though anyone was giving her the message of "it's not just you" when she was struggling.

This lack of support continued throughout their journeys, with OT5 highlighting that they did not really feel there was anyone for them to turn to. One Indigenous OT brought up the lack of support experienced when faculty and staff choose to ignore instances of racism, or handle them inappropriately, which was alarming. She shared a story of a racist comment being made by a classmate, and despite the instructor hearing it, they did not address it at all. In fact, she noted that the instructor tried to move on quickly from it, likely not knowing what to do. Nonetheless, reflecting back on the situation, she highlighted that, "there should be some follow up… There should be some exploring and unpacking and coming to understand what that's about" which she describes as a missed learning opportunity. Another instance described by an Indigenous OT brings to light the differences in values; she needed to take time away due to a family situation, which included needing to support an Elder, and the school was unwilling to accommodate or support this request in any way.

This lack of support is compounded by the idea of *first in family*, language widely used in medical education, particularly in the UK. It refers to the notion that students may face particular disadvantages, and particular struggles when they come from families where no one before them has attended post-secondary education or studied in the health professions. This came up in some of our story-telling sessions. OT5 and OT1 highlighted the fact that they had no family members who had gone through post-secondary schooling prior to them, which left them with few places to turn for solutions to difficulties they were having. Other Indigenous OTs highlighted the fact that *not* being

first in family to attend post-secondary helped them tremendously in their educational experience, which will be explored more fully in a later chapter on creating community.

Nonetheless, a few Indigenous OTs did feel they were relatively well supported in their learning. OT6 felt they had a good amount of nurturing and support, because they felt they had individual instructors who they got along well with. Similarly, OT8 thought they had a good connection with the majority of their instructors, although they admitted that there was still, "moments of awkwardness and inappropriateness." Interestingly, both OTs who felt they had at least a decent experience come from the same geographic area, which could suggest local context plays a role in the supports available and provided to Indigenous students.

Finally, this chapter wraps up by putting forward cautions and advice that Indigenous OTs wanted to share with OT programs across the country.

Cautions and advice for occupational therapy programs

Indigenous OTs involved with this study extensively discussed their cautions and advice for the occupational therapy profession to improve through needed change. We have knowledge to offer that can and should inform the ways in which the profession moves forward to better support the diverse populations we aim to recruit. Therefore, it makes sense for Indigenous OT students and clinicians to be leading the way in conversations related to reconciliation, yet to date, we have not drawn on their perspectives and expertise in any extensive way.

Given that this dissertation is organized to capture education experiences and workplace experiences as separate chapters, similar themes appear in both, yet the goal

is to illuminate key themes pertaining to each context (education or workplace) separately. It is important to note that some suggestions may pertain to both contexts but have been parsed apart to consider where they fit best. The sub-themes discussed below include the need to slow down and listen, advice for Indigenous OT supports (or lack thereof) and augmenting Indigenous content in OT programs.

Slow down and listen

Many Indigenous OTs discussed the notion that the OT profession and OT programs are attempting to move towards reconciliation initiatives very quickly and are not taking the time to deeply understand and consider the work that needs to be done. OT1 talked about what they see as a critical first step before jumping into topics such as Indigenization or decolonization, which involves fully understanding the extent to which OT as a profession is entrenched in Western settler colonial culture:

> "Bringing to light the underpinnings of the profession is a first step. . . they're are so eager to do things. And that's just the way Western society works. It's like, 'Jump on it. Jump on it. Let's try and make something of it.'"

Although they recognize the pressure to do this work is high, moving too quickly can also cause significant harm. OT5 similarly reflected on the need for OT to slow down and noted that, "We're still in the very early stages of even bringing to light the underpinnings of the profession" and emphasizes that we have a long way to go. This point was echoed by OT7, who used almost the exact terminology of "moving too quickly" when considering efforts that are being created without proper time, resources, or consultation. In OT school, the fast pace and emphasis on efficient processes, meant OT7

never felt they had time to explore their identity in relation to the content they were learning. Regarding the rush to Indigenize and decolonize OT curricula, both OT3 and OT6 related this to a "savior complex" present in OT, with OT6 specifically using the term "white savior complex" to describe the constant need to *do good* and *help*, particularly as it pertains to those from marginalized groups. This saviour complex directly impacts how work gets taken up, and may result in resistance to the slow, deliberate, deeply thoughtful initiatives and supports needed to build relations and move in helpful directions.

Indigenous OT supports (or lack thereof)

A key finding that emerged in relation to supporting Indigenous OT students was the *lack* of support. Very few Indigenous OTs commented on their awareness of Indigenous supports broadly at their post-secondary institutions except for OT1 and OT12. OT1 noted that there was no real effort made to connect them with Indigenous resources, and OT12 noted that they were aware there was a First Nations House on campus, but they had no other knowledge of Indigenous supports available to them.

Participants discussed how the profession is aiming to recruit and retain more Indigenous learners in education programs, but there are minimal supports or initiatives for Indigenous students once they get into OT. OT2 commented on how they felt a lack of safety for Indigenous students in their program, with OT6 stating that the profession can't be welcoming and recruiting Indigenous students into the program and "not supporting them adequately". OT4 suggested we start to consider multiple pathways into OT, similar to what some medicine and nursing programs are doing to create cohorts and

community among Indigenous learners. These cohort designs offer a sense of connection and community, while facilitating peer to peer supports, which can in turn help with isolation and belonging.

This theme is also evidenced in the experiences of Indigenous OTs captured above. OT5 noted that Indigenous students are still having horrible experiences in OT programs across the country, and reflected on the fact that she is "still seeing the same crap as when I was in school", which was about 15 years ago. Suggestions from Indigenous OTs included systematic supports for students once they get into the program, rather than stopping with preferential admissions. By not having supports in place, OT5 noted that OT programs are essentially "setting Indigenous people up for failure". OT1 states that these supports need to be Indigenous-specific, and that the profession and OT education programs must stop lumping Indigenous Peoples with other equity seeking groups and other EDI initiatives. This point is a particularly important one to make, given the unique, and traumatic, history pertaining to Indigenous and settler relations in Canada. Settlers and ongoing colonialism has stripped Indigenous Peoples on Turtle Island of their livelihoods, their wellbeing, and their ways of knowing, being, and doing for centuries – requiring a different approach to considering needs, supports, and services for Indigenous Peoples.

This theme will be further explored in Chapter 6 on 'creating community', where recommendations will be made in relation to creating *safer* spaces.

Indigenous curriculum in OT programs

Finally, one key theme, which will be taken up more broadly in Chapter 7, relates to incorporating Indigenous knowledges (Indigenization) into already existing structures and programs in OT. A key point brought forward by OT8 insists that Indigenous content in OT programs be taught by Indigenous people only. They reflected on a time where they were going through a cultural safety course put forward by their OT program, but the instructor was not even from Canada, and had little understanding of Indigenous Peoples' experiences. This point is complex, raising questions about who is 'entitled to' or capable of teaching what kinds of content, and how that links to identity and experience. It also brings to light a broader concern in academia where Indigenous instructors and faculty are expected to have the knowledge and skills to teach *all* Indigenous content, which is likely not the case given the diversity of Indigenous people and Nations. Nonetheless, numerous participants in this study mentioned the lack of representation at the instructor or professor level in OT schools, and therefore this advice requires OT programs to not only recruit more Indigenous faculty, but also to support, and value them as they bring their strengths and unique knowledges into white, colonial spaces.

Further, numerous OTs reflected on Indigenous-specific curricula they had been exposed to during their OT programs, and the majority noted that there was a single lecture on Indigenous health throughout the whole two years, or that they had seen a single Elder be brought in to speak. No Indigenous OTs felt that Indigenous content was sufficiently present in their courses despite reflecting on the need for this. Again, this is not surprising given the lack of Indigenous instructors or faculty, and again illuminates a need, but also a tension given the suggestion that Indigenous content be taught by

Indigenous faculty. This will be further explored in the discussion section of this dissertation. OT12 felt what they were learning was irrelevant to them and their interests, which echoed what OT13 said about the theories, models, and assessments having no relation to working with Indigenous Peoples. The nuances of Indigenization, reconciliation, and decolonization efforts will be explored in a subsequent chapter.

OT4 specifically suggested that programs start to bring in land-based curricula into their programming. This would mean moving out of the white walls of academic institutions and moving towards land-based education in partnership with the Indigenous Peoples on whose land the OT programming takes place. As mentioned, this theme will be further explored; however, given OT boasts holism and attention to how the environment impacts health, this recommendation would be of benefit to not only Indigenous learners but to all.

Conclusion

Overall, Indigenous OTs reported that in their OT training they experienced imposed isolation, lack of support, exclusion, a devaluing of their merit and skills, and the need to work between two worldviews. This was underpinned by the cultural imperialism purpoted by the OT profession. Despite increased recruitment of Indigenous students into health professional programs, Indigenous OT learners are still experiencing significant challenges, discrimination, and racism while pursuing their education. Indigenous OT students are still few and far between, despite an increase in enrolment in recent years. The profession's grounding in, and continued commitment to, one way of knowing, being, and doing – has deep impacts on Indigenous students. Not only does it

result in a shape shifting between worldviews, but it leaves Indigenous students feeling unseen, unheard, and unvalued. This is compounded by the lack of support and representation still prevalent in OT training. Indigenous OTs did what they could to 'survive' on their educational journeys; key findings on how they did that will be explored in the chapter on *creating spaces of belonging* in the OT profession.

CHAPTER 5: INDIGENOUS OCCUPATIONAL THERAPISTS' WORKPLACE EXPERIENCES IN CANADA: YOU'RE STILL 'PART OF THE SYSTEM'

This chapter explores the workplace experiences of the Indigenous occupational therapists who participated in the research. This chapter shares many similarities to the previous educational experiences chapter, with identical themes emerging such as isolation and exclusion. However, this chapter also features unique experiences of Indigenous OTs largely based on context, which in this case is referring specifically to the workplace environmental climate, as well as the nature and types of supports available within workspaces. This chapter illuminates important similarities, differences, and nuances regarding the impacts of working in a health authority or hospital setting in comparison to working within an Indigenous-specific initiative, organization, or community in relation to day-to-day experiences.

It is important to note that Indigenous OTs in this research work in a wide range of places and contexts, which necessitates a structural and systemic approach to better understand their experiences. Therefore, these results are organized to portray experiences based on individual, structural, and systemic levels. The individual level will focus on how Indigenous OTs were doing things differently in the context of working with Indigenous clients, communities, and organizations, regardless of the type of institution within which they worked. Following that, Indigenous OTs share how structural and systemic contexts facilitated or impeded positive experiences within the workplace. It is hoped that organizing the data in this way makes clear how broader influences (e.g.,

workplace climate, systemic policies and procedures, etc) impact the experiences of Indigenous OTs within this study.

Similar to the previous chapter on educational experiences, key general experiences will be discussed through the creation of a short narrative story. This story was created using information from the individual stories heard through this research and is shared in this way to avoid identification of any one individual, while paying respect to the cumulative nature of negative experiences that Indigenous OTs often encounter working in Canadian health care systems.

After graduating, I was pressured to find a job pretty quickly given that I needed to make money to pay off living expenses and loans that had accumulated through my time in school. This meant applying to whatever was available at the time, even if it didn't sound really appealing to me or to my interests. At the time, I put my name out there for any job that lined up with some of the placement experiences I had. I wrote down all the places I put in applications for, and realized it was like seven pages long. I interviewed for a few jobs but found myself really struggling with interview skills and figuring out how to answer the questions they were asking me. Time went by, and I didn't get any call backs. It took me months to even get into a contract job!

The job I ended up taking was a one-year term contract at a hospital. It wasn't my first choice, for sure, but it did get me in the door and helped by giving me an income stream, so I accepted and off I went. The majority of clients, I had come to learn, were white, but there were a few Indigenous clients that I was able to work with. There wasn't a ton of handover from the previous OT, but they did leave detailed notes, so I spent some

time going over what they had been working on, trying to figure out what the heck I was supposed to be doing. The more I read on my own about what my OT role was going to look like, and what was expected of me, the more I started to think that there must have been some mistake that they've hired me here, because now I am not sure that I fully understand OT, what an OT does, or what I'm actually supposed to be doing. I felt like in OT school, I had a hard time grasping what was expected of me and didn't really resonate with a lot of the curriculum. So, these concerns, questions…continued into my workplace experiences. It didn't help that I was the only Indigenous person working on this team.

I thought – this is stupid, of course I know what I'm talking about. I must – right? I have a Masters degree. So…I did what I had been doing all along. I felt I had to pretend to know what I'm talking about, and fit in, and learn the language that other people are using in this space, so that it sounds like I actually understand that system. The next few weeks..months.. are a bit of a blur, honestly. When you think of the phrase "fake it till you make it" that is truly what I felt like I was doing, but I never quite reached the finish line of feeling like I ***actually did*** *make it. Most of my job entailed getting people back to their previously enjoyed or needed to do activities, which included things like grocery shopping, kitchen skills, the full gamut, honestly. I think the clients that I was working with, or at least some of them, also got the impression of how weird some of the OT stuff was that I had to do. The only way I can describe it is that it just didn't feel right. It felt fake, and I felt like an alien in this space.*

While I was trying to figure out this new role, I was also dealing with a lot of racism.. My boss was incredibly racist. Now, mind you – this was before the TRC or

anything had come out, and it just didn't seem like the institution I was working for cared at all about Indigenous people. We were kind of an afterthought in a system that was not designed for us. This racism was a daily thing – micro aggressions, macro aggressions, it was just constant, directly at me (in subtle ways) and directed at Indigenous clients who came to seek our help in much less subtle ways. The differences in care were astonishing. Looking back, I realize there was a lot of things I should have said, or could have said or done, but I was honestly just trying to survive in that moment, in that job, in that space. It was my first job, and I felt really insecure after coming out of my OT school training, so I just put my head down, didn't cause any fuss, and tried to do what I was supposed to be doing, which was helping people do things, I guess.

This worked, temporarily, but people around me could see how it was impacting me. I tried to process it with my family and friends, and they were a great support, but I still had to get through the 40-hour work week. I felt invisible at work, and that was painful, but at the time, I felt like I made myself invisible purposely so I blamed myself. I really just internalized a lot of my failures for a long time because of the systemic racism and microaggressions that I experienced working in the hospital setting. I think what made it a lot more difficult is that there was no one who looked like me on our health care team, and I didn't know of any other Indigenous clinicians (not just OTs) in the hospital. I toughed out my contract because I desperately needed the money, but I knew that as soon as it was up, I had to come up with another plan because I just couldn't justify going through this for the rest of my life. I actively started looking for jobs working with

Indigenous communities or for an Indigenous organization because I thought I would feel more like I belong, and that I would be more valued, heard, and seen in that context.

I was thrilled when I got a job working for a health board within an Indigenous community. I talked to my family and friends about the excitement for something new, although there was a gap between finishing my original job and starting the next one, so I had a few months of no job, which left me in a horrible place financially. At the time, I felt it was worth it – and that this move would solve most, if not all, of the issues I was experiencing working in a hospital setting. Well….things didn't go as planned.

I didn't stay with this health board for very long. Yes, it was an Indigenous community, but there were no other Indigenous healthcare professionals, to my surprise. And it was actually really, really racist. I felt duped – I truly thought things would be different, and they weren't. I assumed (incorrectly) that working for an Indigenous health board would necessitate working with mostly Indigenous people, who understand how health care services need to be different for Indigenous people. What I got instead was push back about how we still need to operate in these colonial systems, even if we are an Indigenous-specific organization. We were being asked to use these standardized assessments and things, because of funding parameters, but this felt so awful to me. The one good thing was that I did indeed get to work with a lot of Indigenous clients, and that's when I felt the most at home. Although, I did need to do a mental health assessment with an Elder once, and my only way to describe that was 'icky'. I still felt like I was new, and novice, and didn't really know what I was talking about, so again – I think I hadn't really found my voice at that point yet. On top of that, the racism was similar to

my hospital experience, which almost hurt more because I thought, 'Gosh – if this is happening within an Indigenous organization, to someone who is part of the health care team, I can't imagine what kind of treatment some of these clients are experiencing from these non-Indigenous clinicians'.

I stayed there for a few months, and then was back on the job hunt again, trying to figure out what I wanted to do, and where would be a good place to do it. I moved around jobs a lot in the next few years – I would start at a new place, full of hope, which I found would be quickly dashed. If you looked at my résumé, you'd be surprised at how many places I've worked, and that doesn't even include all of it because there were jobs that I just left without significant notice, and so I figured I burned that bridge, and they wouldn't give me a good reference at all. But, what they didn't understand (and didn't even bother to ask about) was that I left as a survival mechanism.

I think through these experiences, I have found my voice. I have found a job that I enjoy, although the challenges still remain. I started a consulting business so that I could really do things the way I wanted to and be able to have full control of at least the care people were receiving from me. But, what this means is that I'm creating a new 'thing', or new space, that hasn't really been done before, so it's been an incredible amount of work. But not having to deal with ongoing racism, discrimination, and not having to 'play the game' in a way that seemed inauthentic to me and my values outweighs the amount of hours I have to put in. On top of that – I've been practicing for over 10 years now and do feel like I've found my voice a lot more. I am a lot more comfortable speaking up when I don't think something is right, and I'm a lot more comfortable in sharing who I am, where

I come from, and what I bring to the table. This has meant that I'm also more comfortable in my clinical practice, ensuring I recognize and validate the complexities and lived experiences of the Indigenous clients I am working with – many of whom I share common experiences with. That journey has been hard, and it's taken me a lot of years, and a lot of building up my own little support network or community to be able to do that. Because, often times we work in systems where if you rock the boat too much, you suffer for it. You're labeled a troublemaker, you're reprimanded, or isolated. Those consequences work to keep people maintaining the status quo.

One of the things I find so interesting is that now that the TRC Calls to Action and MMIWG2S Calls to Justice have come out, being an Indigenous person in this profession results in a lot of asks, or inquiries, or favors. I'm suddenly in demand! I just find it so ironic because when I first started in OT, being Indigenous was a problem, but now – it's a sought-after identity marker, but only for extraction purposes. Do I get a million asks to be a part of things, to share my thoughts, to sit in colonial spaces? Yes. Do I feel truly valued and appreciated as an Indigenous person who has kick ass skills and insights to offer? No. That irony is the main reason why when people ask me if I think things have changed significantly over the past 10 years, my answer is usually no. I think we're in an era of performative engagement with Indigenous people, which is still extractive. Often, these 'things' or 'opportunities' as some people call it to 'enhance my résumé' are unpaid labour, or at least seriously underpaid. That sounds jaded, and I should qualify it to say we have made some progress, I just don't think I'm going to see (in my lifetime) the kind of

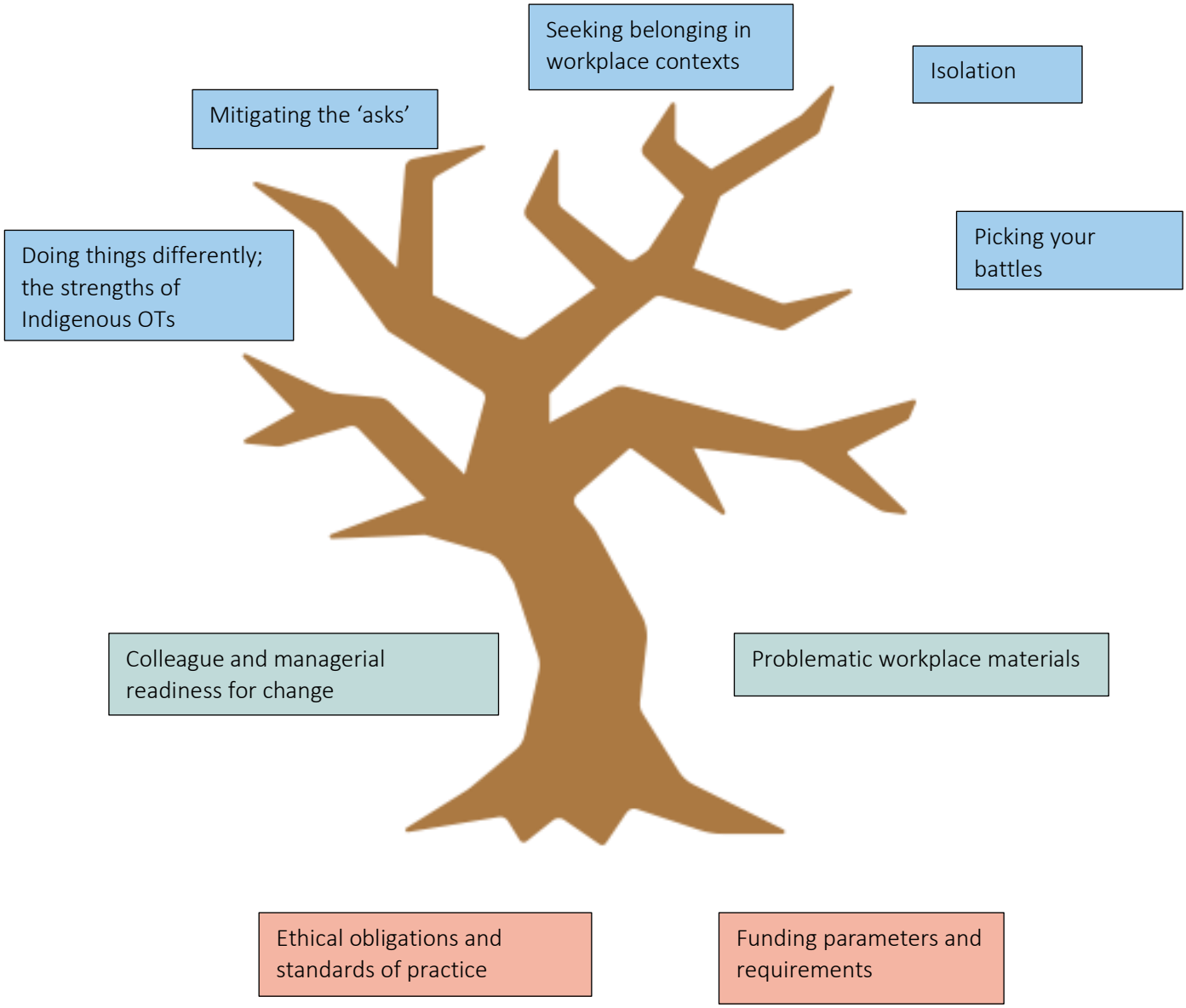
work that I think OT is capable of if the profession could practice what it preaches: flexibility, holism, and collaboration.

Occupational therapy in Indigenous contexts

One of the major themes that emerged from this research concerns the ways in which Indigenous OTs did things differently when working with Indigenous clients, with unique insights into the challenges they encountered when doing so. It's important to note that participants worked in a wide variety of contexts; hospitals, long term care, private practice, consulting, or with Indigenous-specific organizations and communities. These experiences are further contextualized based on geography and local Indigenous communities. This diversity in workplace contexts for Indigenous OTs requires a presentation of the results that highlights the individual efforts put forward, as well as the structural and systemic barriers and facilitators to working with Indigenous people and communities *in a good way*.

I have chosen to present these themes using a tree diagram, similar to the educational experiences in Chapter 4, however with a bit more depth. The presentation of themes will follow a framework similar to that outlined by Reading and Wien (2009) when describing the proximal, intermediate, and distal determinants of health. Reading (2015) also describes these proximal, intermediate, and distal determinants in the form of a tree diagram, which I have used to visually present my themes. The individual experiences and perceptions will be the proximal category (the leaves), the structural will be represented by the intermediate (the trunk) and the systemic will be captured by the distal (the roots) of the tree. What follows this visual depiction is a thematic description

of these topics and key themes to illuminate the ways in which underlying (and often invisible) structures impact the work being done by Indigenous clinicians in the profession.



Note: Blue = proximal determinants; Green = intermedial determinants; Red = distal determinants

Individual experiences, perceptions, and efforts

Indigenous OTs spoke at length about the experiences in their respective workplaces. Participants were asked to share their story from after they graduate from OT school, including their decisions to enter certain workplaces or areas of OT versus others. Despite the variety of workplace contexts present within this data set, the overwhelming majority of Indigenous OTs spoke about being the only one or one of few Indigenous people at work.

Isolation

Indigenous OTs described numerous instances where they were the only Indigenous OT, or even the only Indigenous clinician within their workplaces. This is not a surprising finding, given the previous chapter on education experiences focused heavily on the impacts of being the only one or one of few Indigenous people graduating from OT, however this was a finding across workplace contexts, including for individuals working in Indigenous-specific communities, organizations, or initiatives.

Some participants are or were employed in mainstream institutions such as health care facilities, hospitals or academia. In all of those spaces, each participant experienced being the only Indigenous OT in the department and being the go-to person for all things Indigenous health and wellness. Two Indigenous OTs felt their institutional workplaces had been supportive of them as Indigenous clinicians; perhaps worthy of note is that both come from the same geographic area (Western Canada), and both are relatively recent graduates of their OT programs. Of the 13 Indigenous OTs who participated in this work, none are working within hospital settings currently on a full-time basis. OT8 is transitioning into a position that is partly hospital-based, after working

within Indigenous communities. Even more interestingly, this OT went on to qualify that the employment opportunity is with a small hospital, and only serves the population in the immediate area, alluding to the fact that this context influenced her interest in taking the job.

Nonetheless, the isolating experience of being the only one or one of a few is similar even when therapists are employed to work with Indigenous people. Out of the 13 participants in this study, 8 are working within Indigenous communities, organizations, or initiatives, yet are often isolated. For example, OT7 talked about being the only Indigenous OT working in their organization currently, yet they work in an Indigenous-specific initiative on the West Coast. This finding was echoed by OT3, who stated that: "[Almost] all my colleagues are white" and OT13, who shared that they had originally started working directly with Indigenous communities and quickly found out that most colleagues in that workspace were non-Indigenous. Both OT3 and OT13 worked in Indigenous-specific communities and initiatives at that time. Notably, OT8 had employment lined up with Indigenous communities prior to graduating. When asked whether they had experienced any racism or discrimination in their workplace, they spoke of the fact that many of the communities they ended up working with were close to their home community. This meant that they were well known through their family connections, which may have acted as a buffer for negative experiences related to being one of very few Indigenous clinicians in the organization. Importantly, this finding speaks to the ongoing issue of capacity – there are not enough Indigenous clinicians to ensure

that Indigenous Peoples and communities have access to practitioners who share similar values and worldviews.

Because of these experiences, a few people have branched out from working within existing systems and have started their own OT businesses, which allows for greater flexibility and the ability to do OT in different ways compared to being employed within pre-existing colonial institutions and health authorities. Another OT has, for the most part, left the profession altogether due to the fatigue of working in a system not designed to support or protect Indigenous Peoples and communities. For others, for example OT1 and OT9, selective disclosure played a key part in mitigating racism and 'asks' due to being the only one or one of a few, yet this option is not available for everyone depending on outward appearance.

Being the only Indigenous OT or one of a few Indigenous clinicians broadly within their respective workplaces has far-reaching impacts on one's health, wellbeing, and sense of belonging. It can be exhausting and dispiriting. The following sub-theme focuses on the lack of belonging Indigenous OTs felt in their workplaces, which again mirrors the findings from the educational experiences chapter.

Seeking belonging within workplace contexts

At the beginning of this research, I had naively assumed that individuals working with Indigenous communities, organizations, or initiatives would inherently find more belonging in those spaces in comparison to Indigenous OTs who are working in mainstream, non-Indigenous settings. Findings from this research demonstrated that is not the case. Almost every Indigenous OT (but not all) who participated in this research

alluded in one way or another to a lack of belonging in workspaces. Belonging in the workplace seems to be dependent on context. Some Indigenous OTs spoke about their efforts to belong through doing extra work. For example, OT2 stated that: “I think I have to do a lot of work wherever I am, to fit in, in some ways”. Given the disruption to identities and cultures through colonial practices, it is not surprising that OT5 talked about a lack of belonging in both Indigenous and non-Indigenous settings: “In a predominately white space, I almost never feel like I belong…I don’t always feel like I belong in an Indigenous setting either.”

The notion of a lack of belonging in both Indigenous and non-Indigenous spaces highlights the complexity of factors that impact belonging in particular contexts. Two therapists, OT4 and OT6, had no major concerns regarding a lack of belonging; both are located in Western Canada. Other Indigenous OTs, notably, OT10 and OT12 spoke of a general lack of belonging, with OT12 stating that they “don’t really feel connected to the profession.” OT10 shared that they feel they belong in certain spaces and not others, while OT9 spoke at length about how they created spaces of belonging in the context of working in a mainstream hospital setting:

> “I didn't really connect with a lot of people I was working with, ‘cause I wasn't coming right out of OT school and planning a big wedding, or you know, maybe with that big class divide too, I found myself probably gravitating towards like, older clinicians who had done more like the Bachelor's level, and so kind of went to teams where I really enjoyed working with people and could have conversations about maybe what I was doing and could have conversations

about, you know, some of my challenges with standardized assessments and didn't necessarily feel judged about them."

An interesting reflection from one OT emerged in relation to belonging. When prompted about whether they feel like they belong in the profession now, they responded saying they did feel as though they belonged, but that was because they had moved their practice away from pre-existing systems. Although OT7 didn't talk about belonging specifically in relation to the workplace, but they shared an experience where they were asked by a client not to come to a meeting pertaining to their care, and they quickly found out that only the racial minorities on the team were asked not to attend. This is a clear instance of deliberate exclusion in the workplace, and though it is always difficult to challenge a client, this moment of racist exclusion was challenged by no one. This creates a workspace that is experienced as hostile or isolating.

When belonging is not guaranteed (or even likely) in professional work contexts, and Indigenous OTs are isolated and excluded, left to do the work of creating connections (where possible), the everyday work of OT can be exhausting, filled with invisible practical, social and emotional labour. The next two sub-themes – picking your battles and mitigating the 'asks' – are a direct result of the lack of representation of Indigenous OTs across the country.

Picking your battles

Several participants in this research spoke at length about the need to pick their battles in relation to workplace conversations. OT9 noted that, "As an Indigenous person, we are always educating"; yet how that education role is taken up varies. OT7 shared

that she feels she is constantly challenging colleagues, which results in her being labelled as a 'disruptive OT' which seems to point to issues on the receiving end of this education. When taken-for-granted practices, assumptions and beliefs are challenged or questioned, the response is frequently anger and defensiveness. Nonetheless, OT7 spoke about how she feels a responsibility to ensure at least safe(r) practices are happening with Indigenous communities, by continuing to question and challenge.

When, and how, you go about picking your battles was an important topic of conversation. OT3 shared that: "It's going to be exhausting if I constantly bring up something that I disagree with," alluding to the idea that there are numerous things she may disagree with in her workplace; how she negotiates what to take on *versus* what to let go is less clear. She alluded to picking her battles based on things she can or absolutely cannot let slide, meaning that if the issue is serious, she will speak up. She also shared that she felt her workplace really did not care that much about some of what she was bringing forward, which is interesting given she's employed in a role working with Indigenous communities. OT7 goes on to share how she engages with what she refers to as "walking a fine line":

> "[I tell people] 'I identify as a First Nations person. This is my background. This is why it's important to me. And this is my thoughts on this work.' So obviously, it's quite clear that, you know, it's important to them, in some senses, that I bring that lens. But also, it often felt like, you know, I'm walking a fine line here. Like, if I say one more thing or if I continue down this road, what is going to happen to me? And then, like, ultimately, what is going to happen? So, a lot of the times, I

> would just like, leave things. I, you know, if things really were not okay with, um, like work situations, I would just leave them, because it wasn't worth it to me, and it was causing too much friction. And so, because I felt like I was walking that fine line of like, 'This could go either this way or this way.' And I think it's actually going down the negative road, and you know, this is my career on the line, and I want to be, I'm a respectful clinician and I truly believe that, and so, I want to continue walking down that line, but I also want people to listen to me."

This constant work of deciding whether to speak up or not took a toll on this person in a significant way. There is a constant and complex internal negotiation that may never be spoken about, yet it has deep impacts for the individual who is going through it.

Some OTs, such as OT3 and OT9, also alluded to the fact that how you go about picking your battles is also dependent on experience, maturity, and age. For example, OT9 talked about how early on in their career, a lot of their battles were simply pushing back on the stereotypes being perpetuated and educating on things like standardized assessments and perhaps why one might choose not to use these with Indigenous people. OT9 then shared a story about providing education to a provincial health service on Indigenous health, and being confronted by an individual ranting about how Indigenous people shouldn't be playing the victim. That individual then demanded of OT9, 'What do you want to do to fix it in [provincial health authority]?' At the time, she responded saying, "I have no idea!" This confrontation has led her to change the way she approaches education and challenging others in their thinking and beliefs, making sure

the responsibility for change does not continue to rest on the few Indigenous health professionals:

> "At the time, I felt so guilty. But looking back, I'm like, yeah, I was in OT for, like, five years. I'm like 'I don't know.' Like, that's what I've kind of learned with my position over the years, is to maybe just ask questions, to say, like, 'This isn't working. Now it's <u>your</u> job, as the people in power, to like, figure out how to fix it.'"

This story illuminates a question that is asked frequently of Indigenous clinicians providing education on Indigenous health issues. There is an underlying message here about Indigenous OTs being expected not only to educate others, but to constantly adapt and grow in their educational strategies to find the just-right balance of naming problems, raising questions, and resisting sole responsibility for solutions. OT11 also shared quite a few stories about trying to enact meaningful change in a system that is rigid and at times unwilling to hear it. With time, experience, and age has come a different perspective on picking battles in the workplace:

> "[This] will be the first year where I'm speaking a little more directly and a little more plainly all the time, instead of having something else going through my mind, and wondering how to convey it, or fear, or like, you know? Cause I'll be able to hopefully do it in a good way or just trust – take a little more risks. You know? Where, cause I just, I guess I've always been so, playing everything close to the chest, because I don't want to be seen as a 'guns blazing, social justice warrior'. Like I don't want to be disparaged. And so, I play the long game. But

then, it's this constant push and pull of feeling like you're not doing enough. So I'll have to continue playing that game a little bit, but trying to get a little more ah, direct. Because so far, I've been received well, and I have to trust that I do have a way of doing it with kindness."

Again, there's an underlying message here about the work required of Indigenous OTs to not only confront, challenge and educate, but also find ways to do it 'just right' – not too fierce, not too direct or too indirect, not doing too much or too little, making sure to do it with kindness in order to be well-received. There are important words here, about fear, risk, and being disparaged, that are the less-visible terrain Indigenous OTs walk as they pick their battles at work.

Other OTs conveyed "choosing their battles" differently. For example, OT12 chose a very particular battle by leaving the profession altogether, for their own health and wellbeing. Both OT5 and OT13 chose to deliberately leave jobs where they were experiencing racism and discrimination and start something new, on their own terms. Interestingly, despite many Indigenous OTs feeling bogged down, or having to deeply negotiate how, and when, to say something about situations or practices they are uncomfortable with, we are still continually looked at to take on extra work and do things in the service of advancing reconciliation. There is a level of irony in the idea that our knowledge is only valued at certain times, or on certain agendas.

Mitigating the 'asks'

Almost every Indigenous OT spoke about being asked to do things <u>because</u> they were Indigenous – often for free. There was an inherent tension that participants spoke

about, which OT8 spoke to briefly, concerning wanting to seize opportunities to make a difference, yet recognizing the element of exploitation at play:

> "I do now, you know, one of my instructors reached out – she's going to have me be a guest lecturer in one of her classes, for one of the first-year classes in, I think it's November, October or November. So that's pretty cool. Like, they're wanting to include Indigenous voices and Indigenous OT voices."

The need to include and consult with Indigenous people to advance reconciliation necessitates a huge number of 'asks' being fielded to a small number of individuals. OT10 noted that they are often asked about how to work with Indigenous communities broadly, or even to provide education to others on Indigenous health. Further, OT1, in relation to deciding how to respond to these asks, said, "I don't want to be saying no to opportunities that I think need Indigenous input, but I also just don't have the energy or the, I don't have it in my soul to give all of that." They go on to also illuminate another issue with drawing on the same group of individuals for *all things* Indigenous: "I don't represent all Indigenous Peoples, we need more robust systems of engagement and solutions that are multisystemic, not burdening or overextending Indigenous people's capacity." OT4 also shared a similar sentiment, reflecting on the fact that they are invited (all the time) to sit on different committees and contribute to workshops, saying, "It can be exhausting, being the only one…or one of few."

These 'asks' are also, more often than not, unpaid or for very low wages, which conveys the value placed on our knowledge. Numerous Indigenous OTs (e.g., OT1, OT5, OT9, OT13, etc) highlighted this as a key issue. OT13 said of being asked to contribute,

repeatedly, “Ah, yes, and it's a lot of unpaid, or it's a lot of unpaid or significantly lower than my wage.” Similarly, OT8 described being unpaid for an extensive presentation they were asked to do – they were actually given a small gift card for coffee without any consultation on an appropriate fee. She went on to say: “I felt extremely, like, tokenized and disrespected. . . I felt taken advantage of, my time and what I shared.” When folks have been offered sufficient compensation for their work – it changes things, for the better. OT9 talked about how, “Just being paid opened up some doors, so again, it maybe just speaks to that importance.” Choosing not to adequately compensate Indigenous OTs for their knowledge and expertise risks losing those contributions, which would be a major loss to the profession of OT.

The timing of these ‘asks’ was also discussed by some. OT5, who has extensive experience in Indigenous health advocacy, shared that she has gotten several invitations to be on grants that have already been written. Her response to them: “Nope. Because the amount you already stacked the deck against me, by creating it from a white Western perspective.” In the context of the TRC and MMIWG2S calls to action and justice, many grants require an Indigenous person to be involved, particular in work relating to Indigenous Peoples themselves, yet OT5’s experience points to the inclusion of Indigenous knowledge and expertise being more of an afterthought. OT12 had a similar experience with the timing of ‘asks’: “You know, there's this interest in decolonizing and reconciliation and all of a sudden, everyone's interested to get my knowledge or for me to be on their committees or to contribute. And for the most part, I'm not interested.” OT13 calls these types of asks ‘extractive’ in her reflections.

These bigger asks are also in combination with the smaller, yet still very time consuming, day to day 'asks' that we get as Indigenous clinicians. Questions like 'Could I run this by you?'; 'What are your thoughts on this?' are things often encountered by OT7, yet these things take significant time away from her own clinical work, leaving her wondering what she has to show for all of this informal consultation and engagement. OT9 shared a similar reflection about her career trajectory, which left her wondering how taking on all these asks has impacted her ability to get ahead. OT11, when reflecting on how she feels about being asked to do so much, all the time, said that she feels a little bogged down. OT9 shared a similar sentiment, saying: "I feel like so many stories are me just crying. But I just like, broke down on the phone with (name). I was like, 'I can't do this. This is too much.'" These findings present a particular dilemma for the OT profession broadly: How to navigate the issue of capacity and lack of representation in a time where Indigenous knowledge is so needed, at every stage, and in every room?

Despite the frequent negative experiences Indigenous OTs have endured in their respective workplaces, it is important to highlight the strengths that we bring to the OT profession. Indigenous OTs were asked about how they did things differently, in the context of their work with Indigenous organizations, communities, and people, illuminating key ways that we, as individuals, actively bring ourselves and our worldviews into the work we do.

Doing things differently: the strengths of Indigenous OTs

Key features emerged when Indigenous OTs reflected on how their practice within Indigenous contexts looks deliberately different. Many spoke of key features that

are often shared values among Indigenous Peoples and our cultures. Before discussing these key features, a quote from OT12 speaks to her level of comfort in doing things differently towards the end of her OT clinical practice as well as highlighting the internal tension that many Indigenous OTs face while working in colonial systems:

> "I think towards the end of being like, involved in clinical, I did [do things differently]. 'Cause I felt, I feel like I was really trying in the beginning to fit within the models, and do things very, very prescriptively, and towards the end, it just, it didn't feel like I was really being, like, there wasn't, I wasn't really reflected in that as well, and I wanted to, like, approach people or work with people, from, like, as an individual, like, as a person, not as an OT. And, yeah, it still felt really gross though."

This 'really gross' feeling that OT12 talks about at the end of the quote is a key driver for her and many of us to try to do things in a way that meets the needs of who we're working with, while also remaining within the parameters set out by our profession. Nonetheless, the below key features highlight important ways that these Indigenous OTs are bringing themselves and their unique skills and abilities into their clinical practice with Indigenous people and communities.

Relationships and relationality. Although our profession professes a focus on relationships, Indigenous OTs felt the way they conceptualized relationships and relationality in their work was fundamentally different than the ways in which the Western OT profession does. OT7 highlighted how they often spend more time in the relationship-building phase with Indigenous clients, and noted that they feel in Western

OT methods, the OT is very much still leading the conversation, which is inherently different from what she strives to do. Further, most Indigenous OTs talked about how important relationship building was in the context of the work that they do – particularly given the historical context of Indigenous/settler relations in Canada. This was demonstrated by OT2 saying, "You have to spend time getting to know them." Similarly, OT3 stated that, "Relationship building is super important to me," and OT6 noted that, ""It's all about relationship building to me. My entire life is relationships. I would not be doing any of the things that I'm doing if I didn't have the mentors and connections that I've been so blessed to have."

How individuals go about building relationships differs, but many of the Indigenous OTs talked about the importance of introducing ourselves and sharing who we are, why we are present to work with a client, and providing as much detail as possible. OT1 said that giving that context is so important, with others such as OT2, OT3, OT12, and OT13 saying they often share their identity and who they are as part of the relationship building process. OT8, who works with Indigenous communities, shared that they at times will make huckleberry tarts for Elders and give them out, saying that, "I do things outside of just my role as an OT that I've always done and that's still part of who I am as an Indigenous person" highlighting how relationship building is ongoing, and important outside of our standard OT roles. OT13 shared a story of how she and another health care provider bonded over their shared attendance at Sundances, which further allowed for the development of a deeper, and more genuine, relationship. This in turn, ideally, allows for increased collaboration to better support the people they are both

working with. Others, such as OT10 described how speaking in Cree with clients fosters a different kind of relationship in comparison to speaking English, although she still emphasized that building relationships takes time because "it takes a while for people to warm up."

This relationship building goes beyond just the individual client. OT4 and OT8 talked about how relationship building extends into the family unit and even beyond. OT9 powerfully described her thinking in relation to building relationships and community connection:

> "Who do we bring in? Who can we ask? Who has these skills, and it's just been probably a bit of, just how we've coped. But it just feels, it just feels very natural, because we just don't do things in isolation. (laugh) Like, it just, that rugged individualism just doesn't really fit. So, again, we've been able to create something for us, hopefully, one day, there's more."

Responsibility. Indigenous OTs also highlighted the responsibility they felt to practice *in a good way*. Whether it's educating the next generation of OTs, or a personal responsibility to improving the health and wellbeing of Indigenous people in their community, Indigenous OTs reflected on how this responsibility impacts how they approach their work. In this chapter, I have captured responsibility, and subsequently, reciprocity, as Indigenous OTs often reflected on responsibility and reciprocity alongside one another, emphasizing a particular responsibility towards ensuring reciprocity is deeply embedded in their practice.

OT8 talked generally about the responsibility they feel to provide the best care possible to Indigenous people they're working with, given the trauma they have faced within colonial health care systems. This sentiment was echoed by OT11, who reflected on the role of health practitioners working with Indigenous communities: "We have a super huge responsibility to like, never forget how horrifyingly it's been done in the past. So, we don't inadvertently replicate past harms."

OT1 talked about how, in the context of a teaching role, they felt a responsibility to ensure new graduate OTs are educated on the colonial history of Canada and the experiences of Indigenous people, to mitigate potential harm. This was echoed by OT9 as well, who discussed our responsibility towards furthering knowledge: "We have responsibility, I think, to mentor the next generation of leaders," yet also in the same sentence reflected on the time constraints and lack of capacity to do this extensive work. This highlights the reality we are currently living in, where Indigenous people are needed in every space to contribute to important conversations about things that directly impact us, yet we do not have enough Indigenous people in these spaces to satisfy current needs. This issue is another problem often placed solely on the shoulders of Indigenous people to figure out.

In relation to reciprocity, OT2 talked about the idea of 'knowledge exchange' in the context of the give and take of knowledge, which OT1 also alluded to in their discussion of what students bring to the table, and how they've learned just as much from students as students have learned from them. This sentiment was also expressed by

OT13, who spoke about how in her work with Indigenous children, she emphasizes their unique and complex perspectives that they bring into the work they do with her.

Holism and holistic practice. Interestingly, our profession boasts a commitment to holism and considering the whole person in practice, yet Indigenous OTs tended to feel their conceptualization of holism is inherently different from the ways it is portrayed in the profession. Some Indigenous OTs, such as OT5 and OT9, referred to this as 'seeing a bigger picture'. OT13 provided a description of how her OT practice in pediatrics pays respect to holism:

> "Because I kind of have to, well, I have to look at so many other factors that just— so like, their fine motor development or their self-regulation. I'm not just looking at the kid. I'm also— I have to look at their family, their community, and what's the history of the community."

OT6 also brought forward the idea of holism, saying that not only do they see the individuals they work with as whole persons, but they also don't actively try to change that, paying respect to who they are in their entirety. OT8, in reflecting on holism, drew out their upbringing as a key factor in their ability to practice in a holistic manner:

> "Like, I don't just, I would like to think I have a very holistic sense of thinking about people and you know, their environments and their contexts and how that influences their life. Like how they're living and their health and their wellbeing. You know? Like, there's so many different impacts. And I think the root of that is, you know, my Indigenous teachings, that inform my Indigenous identity and just how I was raised. Like, it wasn't, that's just how I was raised by my parents. You

know? Being a part of community too, I think is huge. Like, growing up, my parents have always taken me to community events, to ceremonies; they've hosted ceremonies. We've always had sweats and things like that, and different ways of taking care of ourselves, and I think, you know too, with like the period of, we're kind of in the period of realizing how residential schools impacting our families and our communities, right? So I think that, having an awareness of that too is also really important of how that impacts our communities, our people and ourselves. And, how we can hopefully help mitigate some of that. Yeah. So I think my Indigenous identity helps me to think of things very holistically."

Interestingly, many Indigenous OTs, in deciding to go into OT in the first place, did share that they perceived the profession as holistic (e.g., OT5, OT6, OT7, etc), which aligned with their Indigenous worldviews and for some, played a role in choosing which health care profession to enter. These findings presented above indicate perhaps to a point of tension, in that the profession notes holism as a key underlying value, yet perhaps holism from a professional worldview differs in comparison to Indigenous understandings of holism.

Humility, honesty, humour. Although a small portion of the Indigenous OTs mentioned humility, honesty and humour in their work, this sub-theme seemed important to capture given the lack of literature on the ways in which Indigenous OTs do things differently when working within Indigenous contexts. OT1 emphasized humility through sharing with students that she doesn't know everything and is "not the all-knowing teacher". This sentiment is echoed in some ways by OT7 who spoke about

acknowledging the need to go beyond the OT as 'helper' to truly appreciate what the client is bringing to the table in terms of knowledge and values. These two examples speak to humility but also honesty in their interactions. Honesty was also directly mentioned by OT2, who thought that being honest in her identity and background has opened spaces for sharing and prompted relationship building with Indigenous people and communities she works with.

In relation to humor, OT3 and OT10 illuminated how they use humor in their work with Indigenous people and communities. For example, OT3 said that "I don't think way too seriously…." Noting that "OT school is like, unbelievably serious." OT10 talked along a similar line, saying: "Like, we joke around. There's humour and you know, it's just, it's different", speaking to the notion that the way they approach their practice in inherently different with Indigenous communities. Further, OT3 and OT10 both said they appreciate humour and use it in their work; likely as a mechanism with multiple purposes such as getting to know one another and building relationships.

Time and flexibility with time. Interestingly, many Indigenous OTs reflected on the need to be flexible when working with Indigenous communities, yet also spoke about time constraints and working within Western systems as a major barrier for them to be able to *actually* be flexible. For example, both OT1 and OT4 spoke about the rigidity of Western systems, While OT1 also highlighted that despite this, "students need to understand [that] working with community needs to be flexible." OT4 specified that they often aim to integrate more unstructured activities into their OT practice:

> “It really was, you know, throwing on snowshoes and going for walks in some of the local parks. And we did that every couple weeks. Very unstructured. Another thing I would do is like, in one-to-one kind of engagements, like, mental health sort of check visits with people, I would do those on the land, wherever possible”

Similarly, OT2 talked about how they would try to do drop-in sessions, which allowed them to make themselves available regularly and commit to it. She further explains how this helps her practice in community:

> “We've put posters out. We communicate it every time we're there, that we will, you know, (name) the OT will be there on Wednesdays. She will have an open door time at the health centre, between eleven and one.' Over time, as long as you have built those relationships and reached out and really created a safe space, families may actually come to access that service. Or that might break down one barrier for a family, so you can connect with them”

Integrating flexibility into practice was also mentioned by OT11, although not in those exact words. She highlights her approach to practice, and how that stems from her upbringing as an Indigenous person, beginning with a casual and friendly opening of “How’s it going?”:

> “Like, I have a very casual kind of way of approaching my practice, and I think that partially comes from cultural values and the way that I was brought up, but also – why are we just not asking people how they're doing? (laugh). You can get everything from just asking those simple questions or engaging in a conversation.

We don't need to like, trace of a line of process all the way through, right? It's so prescriptive."

Ensuring you are being flexible and holistic when working with people also takes time. This speaks to what OT8 mentioned in her storytelling session around building relationships and the importance of that, illuminating that, "It takes time. It takes sitting down and building relationships."

In order to build the relationships we aim to, and need to, within Indigenous communities and with Indigenous people, we must do things differently than the *status quo* OT expectations. Yet, the reality of being able to do that is hindered by both structural and systemic barriers. What follows is an exploration of how Indigenous OTs were (or were not) able to truly put these things into practice, as well as how barriers at both levels play a major role in the workplace experiences shared earlier in this chapter.

Structural barriers and facilitators

The individual experiences, perceptions, and efforts of Indigenous OTs must be understood and contextualized in relation to structural barriers and facilitators they encounter. Reverting to the tree diagram earlier in this chapter, it is important to consider how the branches of a tree are impacted by how *well* the roots and the trunk of the tree are. It is incredibly difficult to grow beautiful leaves or flowers on the branches of a tree if the tree itself is not well. In the same way, structural barriers and facilitators played a critical role in shaping the workplace experiences of Indigenous OTs involved in this research.

Workplace expectations and procedures

Numerous OTs involved in this research spoke at length about their workplace contexts and how the expectations and procedures laid out allowed them to do, or constrained them from doing, the work they wanted to do. In relation to OT services being provided, one OT talked about how she began an OT role working with First Nations communities but found out that her work already put in place life skills curriculum, which she challenged, deeming it inappropriate for Indigenous individuals and communities. She reflected on the experience by saying that:

> "I started into the job, and they had already developed some really problematic life skills curriculum, to be bringing to First Nations. And I looked at some of them, and just like, it made me uncomfortable. So I can't imagine how it would make, you know, families feel or going into a school. So some of it made me pretty uncomfortable, so I brought it up a little bit, like, slowly. But it turns out, there were a lot of other people that complained about it. So, I just find that, like, when you do have these disagreements, I find that they don't always, it's almost as if they don't care that much."

Even after broaching the topic with her employer, she was left feeling as though they didn't care about how this curriculum may be received by communities, which may result in OTs doing more harm than good through teaching life skills in these ways. Although the OT did not give an example of what the life skills curriculum included, this point speaks to the expectation that all OT assessments and interventions can be applied with any population. Further, this unwillingness to change and listen directly to Indigenous

voices also continues to undermine Indigenous sovereignty and control over Indigenous specific OT programming.

Many Indigenous OTs in this study talked about being encouraged, or even required, to use standardized assessments in their practice. One participant reflected on the underpinnings of standardized assessments and their utility:

> "I mean, the history of actual standardized assessments is, disgusting. It's based in proving people were deficient. Like, that was the reason that they were created in the first place. Like, it's, and so, and then, like, they just don't tell me any more information [than] I can figure out really quickly. Like, if I'm doing a motor assessment, for example, with a kid, I ask the teacher, 'Do they struggle with fine motor skills?' 'Yeah, they can't cut. And they can't print,' or 'They're still switching hands.' Teachers know all that stuff immediately. Like, it's not some sacred information that's only found out through standardized assessment."

This led to OT5 rarely using standardized assessments in their practice with Indigenous people, saying that there is no special information that we can only get through using these means. OT7, OT10, and OT13 all noted that they do not use standardized assessments in their practices or use them very sparingly. OT10 shared similar thoughts to OT5, suggesting that these assessments "have their own issues," providing an example regarding the use of (white Western) developmental norms to categorize deficits in child development. Importantly, developmental norms may look different for each culture and community you're working with, so the use of these assessments, as OT5 says, likely does not tell you anything you cannot figure out otherwise. What these OTs are suggesting is

that standardized assessments are not created for, or tested in the context of, working with Indigenous people and communities.

Other therapists, such as OT3, simply take standardized assessment scores "with a grain of salt." She went on to clarify:

> "So, I, I use them, but I take some of them, like I take some of the questions with a grain of salt, I think, because I can tell that the caregivers or the school staff that I'm working with, I can tell they don't really understand what that means."

This point was echoed by OT9, who discussed needing to be critical about the results of these assessments when working in Indigenous contexts. OT2 said the Indigenous organization where she works has granted her the ability to do things a bit differently. This meant that in the context of OT services through her organization, they are "moving away from standardized assessments and seeing where they fit, rather than relying on them." This flexibility within the organization provides an opportunity, giving OT2 on the chance to make important changes to rehab programming in her organization:

> "What I really want to do is look at where standardized assessments might fit for us, and where they don't. A good example of this is my director, the other day, asked me '(name), how come you haven't ordered any assessment tools? You've been here for five weeks.' And I said 'Well, cause I'm really hoping that at the heart of our new sort of approach to rehab, within the team we have here for child development services, that we really don't need to use them, that we can— 'Cause, we can, we can work together as a team to really figure out where things

are at for families and that we don't, in the end, really need a standardized assessment to let us know that this family is struggling with something."

One major point in relation to standardized assessment scores that emerged through this research is the need to use them for funding approval. OT7, who spoke about not using standardized assessments really at all in their practice, nonetheless reflected on the fact that some funding for families requires a particular score on a particular assessment, even if that assessment is not suitable for the population. OT2 and OT9 also noted funding as a barrier to stopping use of standardized assessments altogether, given that many federal and provincial programs, including third party insurers often require assessment scores. Further, many inpatient psychosocial and physical rehab programs also require standardized scores as part of screening and admission criteria. Therefore, OTs must play the game and use standardized assessments despite their best judgements, to ensure Indigenous people and families have access to the supports they need. This need for standardized assessment scores will be further discussed below as a systemic barrier.

Other problematic workplace procedures that were brought up included critiques of the development and implementation of Indigenous-specific programming – including why it is needed, and why it should be developed by, and for, Indigenous people. OT6 reflected on their work with Indigenous people in their practice and noted that, "I did not feel adequately equipped to help them, in an appropriate way, and so I did my best." This sentiment clearly outlines the gap between what OTs learn in school, and what Indigenous OTs feel is useful when working with their people and within Indigenous

communities broadly. If OTs simply take what they learn in school, and try to apply it within communities, they come up against tensions. OT11, when reflecting on their experience with creating Indigenous specific OT programming for families at their workplace, shared the following:

> “So I'm actually super grateful. I have resigned the management position, and put in a proposal to focus on evaluation instead, because there's just not enough Indigenous families, at the table here. I don't hear anything from them, in anything we do. Very prescriptive. They literally copied and pasted the existing program for white kids, across the province. (laugh) Like, and just offered, and 'That's what we’re doing’ at you. I'm like, 'Oh god. This could be better.'”

She took on a new role feeling as though she could make important change, given the problematic programming her workplace was expecting her to use. OT12 also had an experience similar to OT11. They were attempting to advocate for Indigenous people accessing their group services instead of being sent to an existing program for mood and anxiety disorders which was not Indigenous specific, a practice OT12 disagreed strongly with:

> “It's not an Indigenous service. There's no Indigenous staff working there. And I said, 'No, that's the whole point of having an Indigenous service is that Indigenous people are actually leading the program and facilitating it and working with people and like, incorporating their own perspectives and culture and teachings and we have, like, an Elder.' And there was another program that they spent a pretty healthy budget on, like, training the staff on a particular modality, and

that's what I wanted to do, but there was 'no appetite,' I believe are the words that they used."

The constant need to advocate for programming that is grounded in Indigenous knowledges and led by Indigenous people is exhausting for Indigenous OT clinicians. It's even harder when a commitment to these efforts seems to be important to some workplaces and not others. Most importantly, this OT ended up leaving this organization shortly after, saying they were "sick" of the OT profession. A similar level of frustration and even despair was evident when OT5 reflected on their goal of providing services grounded within Indigenous knowledge. Yet, even the notion of 'land-based activities' isn't enough when you consider the cultural imperialism that the profession perpetuates:

> "Like I know how to tie occupational therapy to land based activities, you know, that kind of stuff. But it's still not enough. It's, like none of it's enough, because I'm still in a system that's like, using fricking Fountas and Pinnell [a classic text] to do reading achievement testing. And they're still three grade levels behind, all the time. Like, it just, it doesn't end.'"

Along a similar line, OT7 noted that it can be hard to think of, for example, emotional regulation in children when there is so much trauma and crises going on in Indigenous communities. OT12 shared a similar sentiment on the need to consider trauma and have trauma-informed training and Indigenous-specific programming in these spaces. Yet, workplace expectations and procedures are not there yet in terms of recognizing and integrating such considerations into OT programming. This has impacts for Indigenous OTs, with OT7 sharing that when things go awry professionally, "it impacts me deeply,

personally" due to the shared identity and experience. So, although Indigenous OTs are calling for change, and attempting to lead that change, their respective workplaces at times make it difficult or impossible to make meaningful change – caught up in the bureaucracy of systems that do not protect Indigenous people and communities. Moreover, not only workplaces, but also managers and colleagues need to be supportive of change, as will be explored next.

Colleague and managerial support and readiness for change

When considering how Indigenous OTs feel in their workplaces, one cannot ignore the impacts of colleagues and managerial support (or lack thereof). Some OTs in this study shared how people at work were supportive, at least in part, whereas others felt they had little or no support from their colleagues and managers, which hindered their ability to feel a sense of belonging and as well as their ability to enact meaningful change to better support Indigenous people and communities.

One major factor that many Indigenous OTs spoke about was their experiences of racism with other colleagues and/or managers. Although this is touched on briefly in some of the above themes, it is important not only to connect ongoing racism to individual sense of belonging, but it also deeply impacts the ways in which we do our work. OT5, OT11, and OT13 all shared overt racist experiences they had after graduating from OT school. OT5 heard comments from co-workers like, "I hate fucking Indians," whereas OT11 shared that they had a very racist boss in one of their first jobs, which impacted the entire workplace. OT13, in their first job out of OT school, was excited to work with an Indigenous organization. They quickly found out they were the only

Indigenous health professional, and experienced significant racism from colleagues. They ended up leaving this job as soon as possible. OT9 described hearing "blatant racism" from colleagues during patient rounds, which led to intensified advocacy on behalf of Indigenous clients, but also hesitation to disclose her own Indigenous identity.

These harmful comments have impacts not only on Indigenous clients, but deeply harm the sense of belonging and safety for Indigenous clinicians. OT3 follows up on this point by noting that their colleagues were mainly white, and they found it “hard managing everyone’s expectations” while seeing ongoing racism happening, yet colleagues did not see an issue. She continued by saying, “I just cannot believe they would think that’s okay” pointing to the lack of awareness from colleagues and managers in relation to the harm they could be doing. This lack of awareness seemed to be framed as ‘not my problem’ in the workplaces of OT7, who said that her colleagues would respond to her bringing up concerns about racism as: “Yeah, I understand that this matters to you, because these are 'your' people,” seemingly pushing away any responsibility to address anti-Indigenous racism. This sentiment was affirmed by OT12, albeit in a different way, when she said that she felt people expected her to “tell us how to fix problems that are not my problems,” suggesting she, as an Indigenous person, should be fixing the harms of ongoing colonialism, and no one else. This deflection of responsibility works to stall, or completely halt, change by overburdening Indigenous people with problems that are not solely ours to fix.

Many of the Indigenous OTs spoke about how their colleagues or managers did not prioritize changes needed to better serve Indigenous people and families. Some were

lucky enough to work in places with relatively supportive colleagues and managers, like OT4, who described being able to bring some of their Indigenous traditions into their clinical practice by doing snowshoeing for mental health support and making bannock in a cooking class. These programs were delivered to both Indigenous and non-Indigenous people, highlighting that Indigenous OTs bring significant value to all OT clients, not just Indigenous clients. When asked how they ended up creating these new programs, and what facilitated doing so, OT4 stated: "As long as, um, I could, you know, justify it in some ways. So like the snowshoeing one, it's the mental health benefits of being outdoors and the physical health benefits, cause it's not easy snowshoeing." This flexibility or support from others in their workplace was not common, however.

OT2, when talking about their own management experiences trying to enact meaningful change in relation to Indigenous health, noted that, "It was never prioritized from my previous managers and directors," and emphasizing "it really depends on what the mandate and support from your leadership team is." OT12 felt similarly; as noted above the typical response she got regarding Indigenous specific programming, was that there was "no appetite" for it. Even in a management position, OT12 felt undermined by lack of support from her upper managers and team:

> "At that point, I had just really checked out and was really feeling over it, because even in a management position, I didn't really have any authority to make any changes that were actually going to be useful. So, I had checked out and I was looking for another – I started looking for other opportunities at that point."

To regularly bring up things that make you feel uncomfortable, and have no support or follow through on anything, takes a toll. OT12 had other experiences in many workplaces where virtually no support was given, leaving her feeling burnt out, and questioning why she was doing all this work in the first place.

OT6 had a similar experience and went beyond that to describe how they felt their management was actively professing that they wanted to change but was unwilling to follow through and actually do any of the work. This leads to outward praise for the organization, while doing little if anything to better support Indigenous clinicians, clients, and communities. OT11 talked about how this made her feel, in relation to putting forward a proposal outlining new ideas and changes with a partner organization:

> "I felt like the impacts of social exclusion and marginalization were happening in real time, where to anyone else, it looks like we're having a conversation. But like, no matter what I'm saying, it's just not happening. So then, I asked for a debrief after. I walked away. Like, my body language showed how I was feeling but at the end of the day, I did thank them for partnering with me, in an unconventional way. And I meant it because I'm grateful that they're at the table here with me. But they're also not doing me tons of favours. Like, I'm helping them meet the bare minimum here. Like, this is behind the times."

In the same session, OT11 talked about how having support from her managers and colleagues in a new job made all the difference. She noted that her team has been a "really huge supporter of me" which she has deeply appreciated. This support has come in various ways such as hearing her ideas on changes to programming and having another

Indigenous OT on staff to bounce ideas off. OT10 echoed the importance of having even one other Indigenous person in your organization. She had an Indigenous supervisor and felt it was "really helpful" in terms of feeling supported. OT7 and OT1 both spoke about the importance of having allies in their workplaces, with OT7 noting that, "Having true allies makes a lot of difference in their awareness when you're getting bogged down and/or overwhelmed as an Indigenous clinician." This point was also stressed by OT9, who described some of the key features of her most supportive allies:

> "Just like I said, amazing mentors, mostly settlers, who are just like, really kind of put their money where their mouth is right? And have shown up and have supported us and taught us how to write and present and navigate."

Indigenous OT workplace experiences are heavily dependent on context, and external support. Workplace procedures and expectations can facilitate or impede the work of Indigenous OTs, in the same way that colleagues and managers can either help us flourish into the strong clinicians we can be, or they can put barrier after barrier in front of us, making it near impossible to do the work we want and need to do. The following section will focus on broader systemic considerations that impact the experiences of Indigenous OTs in their workplaces.

Systemic barriers and facilitators

Systemic barriers and facilitators in this section will consider things that are outside the control of individuals or workplaces. Two key themes emerged from the storytelling of Indigenous OTs, highlighting: 1) funding requirements, parameters and limitations; and 2) colonial processes, ethical obligations, and standards of practice in the

OT profession. Both themes present major barriers for Indigenous OTs doing the work that they want to do to better support Indigenous clients and communities while feeling a sense of well-being and belonging in their workplaces.

Funding parameters, requirements, and limitations

This sub-theme builds on what was mentioned directly above – workplaces often encourage or even require certain ways of doing things. This creates major issues for Indigenous OTs who disagree with these methods, but we also must understand these constraints systemically as well. Requiring Indigenous OTs to utilize particular assessments, curriculum, or practice techniques must be understood at a systems level, where guidelines and requirements, practices and processes, documents and 'acceptable' evidence are determined beyond individual workplaces, by government priorities, policies and programs. To return to the tree image presented above, these systemic barriers and facilitators have a great deal of impact on individual experiences as well as structural contexts. We cannot enact change at the first two 'levels' (e.g., the branches and the trunk) without making meaningful strides to address systemic (the roots) barriers as well.

The demand by government funders that therapists use standardized assessments or particular scoring methods was touched on by many of the Indigenous OTs. OT2 talked about an autism program they have engaged with in the past:

> "Part of our current political climate is that for our families to access certain services, like, the [provincial autism program or their other, like, NIHB [Non-

> Insured Health Benefits] even, or like, that they need to have sometimes more clinical approach to those assessment reports that they send off."

This illuminates the issue Indigenous OTs are experiencing as they try to make their practice culturally safer for the Indigenous families and communities they are working with. OT7 also talked about the need to conduct standardized assessments to secure client funding, noting that they don't use them at all and feel quite strongly that they just don't fit when working within Indigenous contexts. Yet, in order to gain funding, sometimes they are required to do these, even if they are not in the best interest of the client, family, and/or community, and may even harm therapeutic rapport. OT10 critiqued this issue directly, saying,

> "It's not the only way at getting at knowledge and you shouldn't have to go through a standardized assessment to get access to a program or get access to a service. And that's something I really, really struggle with. Like, you can only get into this sub-acute rehab program if you have, you know, a MoCA [Montreal Cognitive Assessment] score of twenty six. Like that is wrong."

The system needs to catch up to the changes happening in real time relating to OT services in communities. OT5 spoke about the need to move away from existing systems, stating that, "We need our own systems, and we need money for them." She suggested we need an OT education program that is for Indigenous OT students, in collaboration with the Indigenous communities we aim to serve, and we also need to have control over funding. From a different angle, OT6 discussed recent efforts to Indigenize standardized assessments. They explicitly mentioned a version of the MoCA

that was designed for Vancouver Island First Nations, yet also noted that when using it in an Indigenous context, “it was better, but didn’t solve any of the problems. The animals were just different.” OT6 didn’t “feel good about this” in any way, even though the assessment was supposed to be more culturally relevant. Participants asked, how can we truly make systematic change when the systems are so far behind what is happening on the ground relating to OT services in Indigenous communities?

Not only is the requirement to do standardized assessments to access funding problematic, but even more broadly the parameters of Indigenous health funding are problematic due to their entrenchment of divisive colonial identities. OT2 noted a major gap regarding Métis people having access to funds. Many funding programs are designed for First Nations, so she said, “there’s certain things I don’t have access to” as a Métis person. This extends to exclusions for the clients we aim to serve. OT6 shared a similar concern, saying the general funding structure is “totally problematic, but that’s a different story.” In their province, which Indigenous identities a person embodies determines which of the different, separated Indigenous health care services they may access, each involving multiple complex steps.

The findings presented here suggest that access to services is seriously impeded at several levels. Both for clinicians accessing funding programs on behalf of clients and for Indigenous people accessing health care directly, systemic funding requirements create a major barrier to making meaningful changes to better support health and wellbeing of Indigenous people and communities on Turtle Island. We must listen to

Indigenous OTs and the barriers they face navigating these systems if we intend to move forward with meaningful action towards reconciliation.

Finally, this chapter finishes by linking barriers that Indigenous OTs are experiencing to the broader colonial context that is the OT profession.

Colonial processes, ethical obligations, and standards of practice

Many Indigenous OTs talked about how colonial processes, ethical obligations, and standards of practice in the OT profession impeded their ability to do their work in a meaningful way, and in a way that meets the needs of Indigenous people. This sub-theme focuses on what Indigenous OTs believe they should be doing to serve Indigenous communities, yet are unable to do given professional regulations, guidelines, and cultural imperialism.

Broadly, OT2 spoke about their engagement with communities in relation to OT services, noting that, "I had learned so much from other people, and from our communities, about the way they wanted services to be done" and yet the institutional barriers she was up against were "killing me inside." OT6 also named the institutional *status quo* as a barrier to making the changes they wanted to. Management and others often said, "We can't do that actually," despite professing an intention to make changes. One OT talked about how even when working with Indigenous initiatives, they still "have to follow all the regulations and the policies and procedures that are set out," continuing to say "that still felt really, not good." It appears institutions are willing to make easy changes but unwilling to do the deep work to address systemic barriers operating to continually marginalize Indigenous people. For example, as OT11 described above, an

institution may be willing to create an Indigenous program – which is good for public image – yet model it on an existing program for settlers, doing little to better the lives of Indigenous people who need the program.

Other Indigenous OTs highlighted the 'lack of preparedness' they felt coming out of OT school and aiming to work with Indigenous people and communities. OT5 talked about not being trained by their OT program to work with Indigenous communities in an impactful way: "You're not necessarily trained in resource settings where there's already such complex problems with access." Similarly, OT6 shared how preparation through colonial education left them ill-prepared for practice in Indigenous contexts: "Going into the homes of Indigenous clients and their families and just realizing I did not feel adequately equipped to help them, in an appropriate way, and so I did my best, my absolute best, but felt like 'This is not fair.'" This was echoed by OT13 who said, "If we practiced the way we are taught in OT school, it is incredibly oppressive in Indigenous communities." This requires Indigenous OTs to not only to learn the Western ways of OT, but also be able to adapt that learning significantly when working with Indigenous people and communities, which requires a very complex set of advanced skills that are never taught and that remain largely invisible. Yet, these advanced skills are beneficial for all therapists to understand and engage with, as it benefits the profession as a whole, not just Indigenous OTs and clients. Importantly, OT1 and OT12 both talked about this in various ways as well, and this finding is directly linked to the lack of Indigenous content and expertise in mainstream OT programs across the country.

Even when they did strive to make changes to their practice to better suit the needs of Indigenous people and communities, many Indigenous OTs questioned the ability to make meaningful systematic change in already existing colonial systems:

> "But, it's, you're just part of the system. Like, you're just part of the beast, essentially. Like, there's no shifting it, and it felt really gross a lot of the times, because you're part of the system that's still keeping people in that system. And you're not really working for them. You're just maintaining the *status quo*. And so that felt really gross. Like morally, not good. So even though I was, like, working, there's the thing too, right? Like, it's one thing to have your values and your morals and then to be in the system which it might not be, those might not be aligned." (OT12)

Others also questioned being part of a system that is not working to support Indigenous health, sovereignty and rights, as OT5 stated: "It's clinging to systems that aren't working for us, and that are actually oppressive to us, and actually damaging to us." OT5 followed this comment with a chronicle of personal experiences of racism and discrimination, speaking to the tension that Indigenous OTs may feel when working in a colonial system that is often harmful. OT1 and OT12 also spoke about the need for our own systems, designed by Indigenous therapists, and for Indigenous therapists. OT12 said, "You can't really decolonize these institutions" and followed up later, commenting, "We need to have our own regulatory College that is Indigenous specific and led by Indigenous people." Until such a dramatic transformation is undertaken, however, we are going to

be required to work in colonial systems for some time until we can begin to establish something that is our own.

Indigenous OTs are working in colonial institutions, and even when working within Indigenous initiatives, troubles still emerge regularly. Indigenous OTs mentioned very specific colonial processes that create discomfort and barriers for them in both Indigenous and non-Indigenous contexts. OT4 talked about how hospital policies restricting visitors are very difficult for Indigenous clients as they often have numerous family members supporting them. They critiqued professional notions of 'holism' in this regard. OT8 shared the same critique, and went on to describe how the idea of 'family' often differs when working with Indigenous communities:

> "For example, a nuclear family, like, only the nuclear family in client centred care even. It's like, that is very different to what, like, like I said, my whole family was a part of taking care of my grandma. My whole family was a part of making the decisions and taking care of her. And once she was in the hospital, you know, all six of my aunties and my uncle were in there, you know, helping with these decisions."

OT5 spoke about issues with the CBFE-OT (the field education evaluation tool for OT students, to be graded by their preceptors) and the way students are assessed on placement, which does not align with the ways Indigenous students may demonstrate their expertise. OT6 talked about how our profession's processes are designed in a way to protect practitioners, regardless of the harm that could be done to Indigenous people and communities. OT12 echoed this, saying that the profession is not protecting "our

people." This point was furthered by OT9, who critiqued the complaints process that is in place when an OT violates their ethical requirements. Speaking about whether an Indigenous person would be comfortable filing a complaint, they said, "No one is going to complain through this, like (laugh) colonial system" hinting again at the notion that professional regulation does more to protect practitioners than the public, particularly Indigenous people.

Further, OT8 talked about the ostensible 'ethical violation' of accepting food from clients when you go into their homes. Continually saying no (as professional standards require), damages the relationship being built. OT7 heavily critiqued the professional expectation of 'not sharing too much' of yourself with your clients, which seriously hinders relationship building. This is compounded when Indigenous people already have well-founded distrust in Canadian health care systems due to racism and discrimination. She also critiqued interviews done to assess 'occupational performance issues', saying that we often focus on increasing or maintaining independence because that is what is valued in Western colonial cultures. She questioned, "Why don't we just ask people about meaning?" OT9 used the term "rugged individualism" in naming a colonial barrier to practice, whereas OT11 talked about the positivist approach of OT and pervasive "clunky OT jargon" as a barrier to engaging in meaningful OT services with Indigenous people. OT10 talked about the way we expect 'professionalism' to look, and the expectations that professionals make 'appropriate' eye contact. She works with First Nations communities, and this is a non-issue; yet this was a huge issue for her when working in Western contexts and also going through placements in school.

Colonial processes and professional expectations like these do very little to support Indigenous people and communities. If anything, they may do more harm. OT1, OT5 and OT7 all spoke about their OT roles in Indigenous contexts and noted a similar observation: It is very hard to see value in OT services when Indigenous people and communities are going through intense trauma, and do not have access to basic necessities to survive, let alone thrive in their environments due to ongoing colonialism. I close this chapter with a quote from OT7 that illuminates the disconnect between what OTs are taught, and expected to do, *versus* how they must practice within Indigenous communities: "At the end of the day, if you go home and you have a house that is like, riddled with mould, and basically unlivable, like, how is my job relevant or meaningful? Like, what does that matter?"

Conclusion

Most Indigenous OTs in this study described problems in their workplace contexts with the expectations of the profession and what they felt they needed to do to provide good care when working in Indigenous contexts. This created problems at not only personal and interpersonal levels, but also structural and systemic levels as well. Further, the individual experiences of Indigenous OTs are embedded in complex, colonial systems that were not designed for us to thrive. These systems have maintained, and continue to maintain, the *status quo* of Indigenous people and communities being perceived as lesser. This narrative must be eradicated and the strengths of us and our People brought forward. If we truly want to move towards reconciliation, we desperately need to consider how the colonial underpinnings and expectations of the profession are making

this near impossible to do. One OT spoke about the desire for their OT practice to reflect "using their gift in a good way," yet this chapter shows how Indigenous OTs are blocked at every turn, in rigid, colonial spaces. As OT5 said, "the profession itself isn't overtly taking a ton of responsibility." The profession as a whole is also not actively seeking out connection and collaboration with Indigenous people, leaving processes of reconciliation to stall or be relegated to the work of Indigenous people only, as we have seen time and time again.

CHAPTER 6: BUILDING COMMUNITY IN THE OCCUPATIONAL THERAPY PROFESSION

This chapter aims to highlight how Indigenous OTs in this study navigated creating spaces of belonging in the profession. This was decided as a separate theme as Indigenous OTs in this study had a plethora of ways they survived and thrived in the OT profession, and it felt important to provide space for that often taken-for-granted work in which they engaged. Given the themes presented in the previous two chapters, it is not surprising that Indigenous OTs in this study struggled to find spaces where they felt valued, appreciated, and acknowledged as unique and important contributors to the profession. Many of them spoke about how they ended up creating and finding community throughout their journeys; and illuminating this 'invisible work' as a stand-alone chapter felt important and needed to do these stories justice. To start off this chapter, I am sharing my own personal story of how I built community in the OT profession while finding spaces that made me truly feel as though I belonged.

This story is taken from a manuscript I published in a Special Issue on Indigenous Health, published by the *Healthy Populations Journal* in collaboration with the Atlantic Indigenous Mentorship Network in Spring 2023 (Volume 3, No. 1). The title of this manuscript is: "*Colliding Identities and the Act of Creating Spaces of Belonging in the Occupational Therapy Profession*" and was written in collaboration with Holly Reid. This publication is open-access and can be found here. Permission from the journal Co-Editor in Chief has been received (See Appendix A) alongside this dissertation. Further, my co-author has consented on the use of a portion of this manuscript in my dissertation.

My journey into OT began in 2017 when I was finishing my undergraduate degree in Psychology. I knew there were virtually no job prospects with just an undergraduate psychology degree, so I decided to explore some graduate programs. I was always particularly interested in health and health care but didn't want to enter nursing or medicine because of the long work hours. Also, as an Indigenous student, I knew quite a few folks who went into typical "biomedical" health care professions and often experienced racism, discrimination, and tensions between their ways of knowing, being, and doing and what was being asked of them in conventional Western health programs.

One of my good friends was planning to apply to OT, and the more I explored the profession, the more I found it resonated with the ways I viewed health, well-being, and health care generally. I was originally drawn to how many spaces and contexts occupational therapists could work in, and how broad the profession was. I applied to OT school, got in, and began the two-year journey toward becoming an occupational therapist. Being from the territory and having my family, friends, and partner here all influenced my choice to stay close to home for my graduate degree. I had a very solid support system here and went into OT school excited and optimistic about what my future held.

My experience in OT school was generally a good one. I had spent many years at that point grappling with my Indigenous identity in relation to colonialism and colonial violence in Canada. My father was adopted into a white family in the 1960s and had all his connections to community and family severed at that time. In relation to education

broadly, I had been educated in Western systems for my entire life and was quite easily able to make myself "fit" into these spaces, at least on the outside.

Although I am a Mi'kmaw woman, I am able to "pass" as a white person, given my light skin tone. This meant that I had the privilege to choose when, to whom, and how I disclosed my identity, and I was also able to mitigate overt discrimination and racism often experienced by other Indigenous students. My outward appearance allowed me to, at least on the exterior, fit in. Another major piece of myself and my upbringing I was able to disclose (or not) was my working-class background. As a first-generation university student, I found graduate school a foreign space to be in, despite already having an undergraduate degree. None of my family were able to help, either. During my OT education, I spent a lot of my spare time in paid work, which made me feel like a bit of an outcast. Not a lot of other students in my program had part-time jobs, and we were discouraged from working outside of school because it would likely lower our grades. The decision not to work was not a privilege I had—and this meant that I missed out on a lot of get-togethers and school activities meant to foster support and belonging in our OT cohort.

It wasn't until I started to learn more about the profession in the first year that I started to realize some congruencies, as well as incongruencies, with my own upbringing, experiences, and identity. Although our profession is described as holistic and client-centred and aligns itself more with a biopsychosocial model of health, it is also elitist, colonial, and exclusionary in many ways as well. I found that a lot of what is taught in OT school is from a particular viewpoint or world view, and other diverse ways of seeing the

world were excluded—never talked about. This made me question whether I belonged in this space and consequently led to imposter syndrome. It felt as though I would have to privilege my Western upbringing and sacrifice many of the teachings and ways of knowing that I've come to learn and understand and that resonate with me as an Indigenous person. I didn't really talk to anyone outside of my closest friends about this at the time, but looking back, I see how different my school experience was in comparison to that of many other students in my program.

At the end of my first year, I encountered a professor I got along with, and I shared my interests in exploring OT through the lens of my Indigenous identity. She used her time, expertise, and resources to support me in exploring who I was, as a Mi'kmaw woman in an OT program, and for that I am forever grateful. It was through that connection that I feel my journey to belonging in the profession really began. I was sure I was one of very few Indigenous students in my cohort, if not the only one, and was eager to get to know more Indigenous occupational therapists to see if they experienced similar tensions and struggles.

In 2018, I connected with two Indigenous occupational therapists in other provinces who welcomed me with open arms (virtually). They met with me on their own time and not only listened to my experiences but validated them. These informal meetings, connections, and conversations continued outside of my formal OT training and work time, and my network of Indigenous occupational therapists began to grow as they supported me in meeting others from across the country. For the first time, I began to feel like I truly belonged in the space I was creating. It was these friendships and connections

that fostered my interest and confidence enough to do a PhD exploring the experiences of Indigenous occupational therapists in Canada. It's important to note that I got into my PhD to explore the experiences of Indigenous nurses, physicians, and occupational therapists, and although this project is important, my ongoing collaborations and connections with Indigenous occupational therapists, and with the support of my supervisors, allowed me to shift my PhD focus to give back to a community that has done a lot for me.

It is also important to acknowledge that around the same time (2018-2019), I began working as the Coordinator of the Atlantic Indigenous Mentorship Network. This new job surrounded me with some amazing Indigenous and allied students and scholars, which played a big role in my sense of belonging and connections with others working in Indigenous health research. Because of this job, I have formed vast connections locally in the Atlantic, nationally, as well as internationally, with diverse individuals who share similar goals and interests. Being able to work alongside Indigenous students, scholars, and communities has continually supported my growth not only as a scholar, but as a Mi'kmaw woman doing Indigenous community-led research. These connections have continued to push me and guide me to the path that I am on today, and getting the opportunity to connect and work alongside numerous other Indigenous graduate students in the region has allowed me to create life-long friendships and professional connections.

Importantly, in 2021, six Indigenous occupational therapists committed to sharing our experiences at the annual Canadian Association of Occupational Therapists Conference. This was one of the few pieces of work "out there" in academia highlighting

the experiences of Indigenous occupational therapists. Although all of us are busy, and consistent communication among us ebbs and flows, the importance of community never wanes. I know that there are other Indigenous occupational therapists out there who have similar experiences and an understanding of where I come from and what I'm going through. Since then, I've continued to build relationships with other Indigenous occupational therapists across the country and have created long-lasting relationships that have changed me as a person, as an occupational therapist, and as a scholar. It made me realize that belonging is not about the place, but about the people—and I'm just now starting to see how I belong in and fit into this profession.

Many people talk about the great friends that they made in OT school, and I made a few good ones, too. But my most important relationships and my sense of belonging within the OT profession were formed outside of my OT program, on my own time. I spent many evenings and weekends on the phone or Zoom talking with other Indigenous occupational therapists. I am blessed to be continually making these important connections through my doctoral work. I knew when my overall PhD project changed, that the consultations and engagement would also look different, given I was proposing to do research with a community that I am deeply a part of.

As my PhD has progressed from my comprehensive exams, to my proposal, to ethics and then to data collection – I have spent most of my time consulting/chatting (often over food and a drink!) with folks who wanted to be involved and see this PhD project through with me. Having support and input from Indigenous OTs across the country will not only make my findings and dissertation stronger, but it has allowed the

idea of an Indigenous CoP to evolve organically into a sharing space of learning, venting, and laughing together. This PhD project has allowed me to spend the time, and even allowed for a gathering at the most recent 2023 CAOT Conference in Saskatoon of a few of us who look forward to getting together and doing this work alongside one another. We are always looking for conferences, events, and so forth to find a way to get together next, which gives me something to look forward to. I look to these folks for guidance, a listening ear, or just to vent about a day or experience I had, and I get these messages sometimes, too. That unwavering support cannot go unnoticed because I truly believe it has made my PhD project and my experience doing this research what it is today. This will continue over the rest of my PhD journey and is something that will continue as I move on to other opportunities as these are lifelong friendships and collaborations.

A resounding statement I hear from Indigenous OT students and practitioners is how much work goes into creating community when you don't automatically belong or see yourself reflected in mainstream spaces (e.g., academia, health care). My story highlights the effort, and need, to create spaces where people can and do feel like they belong. Although my experience is but one of many, I hope that the work I'm doing will contribute to necessary changes in the profession so that Indigenous OT students and practitioners feel supported and valued in the profession.

My story captures one way that Indigenous OTs may embark on seeking belonging in a profession where many do not automatically feel as though they belong. Below I present two major themes that emerged in relation to the focus of this chapter: the act of creating community and finding allies.

Creating community in the OT profession

Many Indigenous OTs spoke about how they did not feel a sense of belonging and community in their OT programs and workplaces. Thus, the creation of community for Indigenous OTs in this study often took extra effort, time, and space, yet was vitally important for wellbeing. OT1, OT6, and OT8 felt that education, for them, was a means of creating community. It is through their education that they were able to connect with others and nurture relationships in the context of the OT profession, although OT1 and OT6 noted these connections often occurred outside of normal class times. OT8 noted that they were able to bond with their classmates but felt that their classmates were "pretty progressive" which likely supported the ability to create like-minded community. OT4 spoke about the notion of creating community by stating: "In some instances, it's like, creating a new community for myself. In others, it's strengthening and re-contextualizing ones that already existed." They went on to share how they've been involved in cultural events through an Indigenous organization, which is where they ended up meeting some of their closest friends. They also brought their family to some of these events, highlighting the strengthening and recontextualizing of relationships they already had.

OT5 spoke at length about the importance of creating community and stated the following when asked about how they've experienced that in the context of informal connections: "whether we're formal or not, it doesn't matter. We still at least kind of know there's some of us that are out there, that exist that we can talk to, and you know?". OT5 went on to highlight being able to bounce ideas off other Indigenous people

(and in particular, Indigenous health care professionals/OTs), and being able to help each other reciprocally, as core values guiding with whom they created community. Yet, they also noted that they felt creating community was "super hard" in spaces where you don't automatically feel a sense of belonging and shared values. This final point illuminates again the extra work that is needed to begin and continue building relationships outside of your formal school and workspaces.

OT9 shared that in their undergraduate degree in Native studies, the sense of community was at the forefront. She noted that the importance of community relations and connection was heavily emphasized and observed that this was not evident in the same way when she entered OT school. This contrast in experience highlights the lack of resources and supports for diverse students looking to find their place in the OT profession. OT1 and OT10 both spoke about support from their respective Indigenous communities, which also played a role in succeeding in their OT program. For OT1, this support was largely financial and opened doors to her being able to access post-secondary education in the first place; for OT10, this was community support in the form of having people in community to lean on and encourage her through her education journey. Yet, OT10, when reflecting on their ability to create community in OT school, felt misunderstood, which made it very difficult to create any sense of community:

> "I feel like a lot of our classmates didn't really understand us. Um, and to just pile that on with the racism, the discrimination, the feeling less than, being told that your history is not valid, things like that, basically, your identity, who you are is, you have to change who you are to become, be in this program, kind of thing."

OT12 had similar thoughts to OT10, and felt they never really were able to create community in the profession. This left them feeling as though they do not belong, with no one in the OT profession telling them otherwise or echoing their concerns and feelings. This ultimately impacted their choice not to remain a practicing OT. These constant hidden efforts to belong and find (or build) a sense of community was difficult nonetheless for many Indigenous OTs but was compounded by the rigour, fast pace, and lack of opportunity to do this in a formal way within OT programs. Indigenous OTs spoke about the importance of finding supportive individuals to create safe(r) spaces for them throughout their journeys, and therefore the following theme focuses on the importance of finding allies to Indigenous OTs.

The importance of finding allies

Given the lack of Indigenous OT students and clinicians across the country, many Indigenous OTs reflected on the importance of finding critical and supportive allies in their journeys. OT1 spoke about a non-Indigenous professor who played a key role in their success, helping make connections with other Indigenous OTs. This professor made a deliberate effort to listen and even took on some of this 'extra' work of creating community for them, connecting them with other Indigenous and non-Indigenous OTs across the country who had similar experiences, values, and interests. Others, such as OT6 and OT10, highlighted non-Indigenous faculty and educators as key to their journey in OT school. OT10 felt that the faculty she had in her OT program were "very encouraging" and shared stories of connecting with faculty from other marginalized

groups as a way to create important connections. Others spoke about finding allies within their respective organizations, such as other Indigenous health care professionals.

Although many Indigenous OTs are calling for spaces that are led by us, and for us, allies nonetheless play an important role in supporting Indigenous students and clinicians in the OT profession. When OT7 felt unheard when bringing up concerns about workplace processes or things that were occurring in their workplace, allies played a huge role in supporting her and making sure she was not alone in her expression of concerns. She shared the following about some of her colleagues:

> "I have this backtrack, a record of you know, this and that, being brought up, like, "How would they listen to me? Would they listen to me?' I don't know. But it's nice that they're, you know, my colleagues who are on the same level as me in thinking and identifying some of these challenges, that they're listening to them and at least something's happening. So that I find comforting, and I don't know if I could continue doing what I'm doing if I didn't have that within my workplace."

She went on to say that these individuals were "Extremely important to me, and my safety as a worker, an employee" which illuminates the need to have supportive allies in your corner as an Indigenous OT. OT9 echoed these sentiments when she shared the role allied academics and clinicians have played in her career trajectory. She notes that she has had "amazing mentors, mostly settlers, who are just, really kind of put[ting] their money where their mouth is, right, and have shown up and have supported us and taught us how to write and present and navigate." This support has come in the form of speaking up when meetings are occurring without Indigenous voices that should be

present, supporting capacity building and taking the time to mentor Indigenous students and clinicians, and making space to share and learn from one another.

Time as a major barrier

Most Indigenous OTs in this study spoke about one major barrier to creating community, which was time. In relation to OT school, OT3 spoke about the fact that they "didn't have much time to think about creating community." This point was echoed by OT7, who felt she needed to focus on school, so they ended up "shov[ing] that identity down a bit" which "left her forgetting who she really was". When asked why she felt she wasn't able to create community much in OT school, she noted that she did not feel she had the mental space for it; she went on to speak about how much effort goes into creating community. OT6 described the lack of community as an "existential crisis" and noted it was hard to focus on school while also finding others who looked similar and shared similar values. Again, like other Indigenous OTs in this study, OT6 went on to say, "A lot of that was done outside of actual school time", which is virtually identical to what OT1 said in relation to their efforts to create community. These findings point to a lack of opportunity for Indigenous students – and perhaps more broadly for students from diverse backgrounds – to create community while going through OT school. OT13 went so far to say that support from Indigenous mentors they connected with got them through OT school. They just so happened to be placed with an Indigenous clinician for a placement, albeit after already having issues on a previous placement due to an unsupportive non-Indigenous preceptor. Their experience speaks volumes to the

importance of ensuring time and effort are invested towards supporting Indigenous students in OT programs across the country.

This finding was also echoed in workplace contexts. OT2 felt that they had a lack of time to create community in their previous job, which was not within an Indigenous-specific context. She felt her workplace had a very individualistic focus on professional development, thus requiring any effort toward creating community to happen in non-work time, or as OT7 states, "Off the side of our desks," a phrase echoed by OT9 in their story of creating community. OT7 described the difficulty yet the importance of ensuring you *do* have community, particularly as a new therapist who is trying to find their way in the profession. It is often "touch and go" she says, where at times she can be very engaged and thinking about developing community, whereas other times, there is simply no opportunity to do so. OT3, who graduated 3 years ago, felt they were just starting to connect with more Indigenous OTs as they get established in the profession. The notion of aiming to create community after a few years of establishing a career and routine was noted as a feasible approach by other Indigenous OTs as well, perhaps because it is not until that point that they felt they had the capacity to do so.

Yet, the desire to be better connected with other Indigenous OTs was shared by almost every Indigenous OT in this study. OT9 highlighted the "power of community" through their story of finding other Indigenous OTs to collaborate and share with. In sharing their experience of friendship with another Indigenous OT, they state that: "I think there was times where we would have probably just gone off the radar but were able to just kind of fill in and balance" which allowed them both to continue their

journeys and support one another. OT8 noted that they would like to be connected to other Indigenous OTs, but there is currently no mechanism in place to do this in the profession. The need to be better connected as Indigenous OTs is the major basis for the next chapter of this dissertation, exploring the potential of creating an Indigenous Community of Practice (CoP). Many felt they did not have much opportunity to do this in school, or in their workplace. OT9 expressed a deep interest in mentoring the next generation of Indigenous leaders, but followed with: "But, where's the time for that?" The tensions between the desire for community and the challenges finding or creating community, between the (unavailable) time needed to forge community relationships and the critical value of those relationships, are borne by individual Indigenous therapists, who feel a responsibility to take up this struggle:

> "There's so many beautiful Indigenous women, like, you, my colleagues I've met. Like, just championing us forward. And I haven't, I've felt for years, I haven't played my part in that yet, and I've had a couple conversations with a couple women, so at least it's a start. And I'm trying to go easy on myself. But there's just so many leaders out there, that I'm continuing to challenge myself to keep pushing." (OT11)

This quote highlights that without systemic support, individuals feel like it is their own personal responsibility to take this on – when in reality, it should be embedded into the system, ensuring everyone can connect and be in relationship with like-minded individuals. This quote also makes clear that the responsibility should not be individual, but collective in nature. This further supports the need for an Indigenous CoP, to ensure

individuals don't feel guilty for being unable to, for various reasons, go above and beyond to build relationships with other Indigenous Peoples when there is limited (or no) formal opportunity to do so.

Conclusion

Indigenous OTs in this research illuminated the often invisible work that goes into creating community and belonging in colonial spaces. They shared the importance of finding allies on that journey as well as noting that time is a major barrier to creating meaningful connection with other Indigenous OTs and Indigenous Peoples, broadly. It is important to contextualize experiences of creating community in relation to the experiences Indigenous OTs in this study have shared in OT programs and within their workplaces. How each of us went about creating community differed, however, the importance of finding a space of belonging in the OT profession was important to everyone, whether they engaged with that importance deeply in OT school or later on in their careers. It is because of the findings presented that I focus the final chapter of analysis and results on the creation of an Indigenous CoP in the OT profession.

CHAPTER 7: CREATING AN INDIGENOUS COMMUNITY OF PRACTICE (COP) IN OCCUPATIONAL THERAPY

This chapter aims to capture ongoing conversations about the need to create an Indigenous Community of Practice (CoP) in the occupational therapy profession. The findings presented here build on the three previous chapters to highlight how Indigenous occupational therapists conceptualize Indigenous sovereignty, self-determination, and resistance in the context of working in a profession underpinned by, and operating from, colonial ideologies. When we understand that Indigenous OT students and clinicians often feel a lack of belonging through their education and workplace experiences and face ongoing (often invisible) efforts to create community for ourselves, the need for an Indigenous CoP in OT emerges organically and provides a way forward for Indigenous students, clinicians, and the profession.

This chapter will begin by providing necessary context on what is currently available for Indigenous OT students and clinicians (mainly the Occupational Therapy and Indigenous Health Network [OTIHN]), and then moves into capturing key features and parameters of what is envisioned and needed for an Indigenous CoP as identified directly by Indigenous OTs themselves. This section will also include a discussion on addressing gaps and key features to consider as we formally develop an Indigenous CoP. This chapter will close by sharing the goals of the Truth and Reconciliation (TRC) Task Force as they apply within occupational therapy in Canada, and how this CoP can move the profession forward in relation to these goals.

Indigenous resources in the OT profession

The OT profession in Canada had virtually no Indigenous specific supports prior to 2009. Further, there were few Indigenous students or clinicians coming through OT programs across the country, and for those who were, resources and supports on the national level (e.g., via CAOT) were virtually non-existent. The OTIHN (a practice Network under the auspices of CAOT) began between 2008-2009 (importantly, this is the same year that the TRC also began its work in Canada) to begin discussions on occupational therapy in relation to Indigenous Peoples' health in Canada. Presented on the CAOT website, members in this group should be: "CAOT members with an interest in building capacity, lobbying for occupational therapy services, and generating a greater discourse on occupational therapy and Indigenous Peoples' health in Canada" (CAOT, 2022). This group is volunteer-based and has a diverse membership base of both Indigenous and non-Indigenous students and clinicians interested in sharing supports and lobbying for improved occupational therapy services with Indigenous Peoples and communities in Canada. It is also important to capture the purpose of this Network, which is: "To provide leadership, networking and support for occupational therapists collaborating with Indigenous clients and communities across Canada." (CAOT, 2022). This Network filled an important gap in the profession, however, the OTIHN is officially ending in September 2023 due to being unable to find volunteer co-chairs to take on these roles. Further, we are now in a time where Indigenous students and clinicians are interested in creating a space that is designed by us, and for us. As one participant noted in the discussion of the OTIHN: "Critique is necessary for forward advancement", and therefore we are moving

forward with ideas that represent our current needs and desires in the OT profession as Indigenous Peoples.

This Indigenous CoP conceptualization moves beyond what OTIHN can offer. Nonetheless, participants in this research felt that the OTIHN was incredibly important and brought us to where we are today. One individual said, “It [the Network] brought us together actually. Like that, thank God, thank God it had its purpose that way”. The Network provided a space for Indigenous clinicians to be involved in important conversations surrounding services within their communities. One participant noted that the Network provided needed space for these things, that had not been happening otherwise. They said, “There's a real lack of education, obviously, in the profession. We know this. Like, this isn't new. But there's a real lack of critical analysis around any of this [Indigenous health] stuff”. During our sharing circle, one participant noted that the Network often serves as a place to discuss assessment suitability, sharing research projects, and its website includes cultural safety resources and readings for clinicians. In the time of truth and reconciliation, one participant noted that we are still in the stage of uncovering truth, and therefore the OTIHN can play a role in that process for the broader OT community.

Yet, most participants in this research spoke about how, for some time now, there has been a need to move beyond what the OTIHN can offer. Participants noted that, “Yeah. We've known for a while we've needed more”; or “it's not enough”; and “this is not effective” and even “may be doing more harm than good”. Broadly, the critiques mentioned regarding the OTIHN included it being a space designed mainly to serve white

clinicians, being volunteer based with limited funding or supports allocated, and not providing a safe space for Indigenous OT students and clinicians to discuss our own needs, concerns, and aspirations. Further, participants brought up the notion of it being a practice Network run by CAOT, thus requiring it to follow the processes and procedures as indicated by CAOT themselves – which does not always align with the needs that Indigenous students and clinicians participants spoke about. These critiques speak to what has been occurring across Canada in relation to Indigenous sovereignty and rights. We have increasing numbers of Indigenous students entering occupational therapy, and we are now in a place and time where we must begin allocating resources to support and retain these individuals, as per the TRC recommendations for health care. While educating allies is valuable work, it also detracts from the work we need and want to do within our communities, and within the collective of Indigenous OTs. It is Indigenous clinicians who are best positioned to continue conversations around supporting Indigenous health, and Indigenous communities, and therefore this CoP aims to fill that gap. Therefore, the following theme captures discussions among study participants surrounding envisioning possibilities and key features of an Indigenous CoP in OT.

Envisioning an Indigenous CoP

During Stage 2 of this research, the sharing circle, Indigenous OTs were asked about their thoughts on an Indigenous CoP, including how this CoP could address existing concerns, and key features and ideas for programming, including short- and long-term goals. The goal of this Indigenous CoP will be to create a space that is designed and led by us, for us. This chapter will begin by linking the overall goal of the CoP as addressing gaps

presented by Indigenous OTs relating to Indigenous-specific initiatives available for us in OT in Canada.

Self-determination and Indigenous-only spaces

Although the OTIHN has been a long-standing resource for clinicians both working and interested in Indigenous health spaces, the OT profession is in an era of actively recruiting more Indigenous students into its programs via avenues such as affirmative action. Over the years, this has led to more and more Indigenous OT clinicians graduating and working in the profession. Recently, Indigenous OTs have been advocating for our own space in the profession to work alongside and support one another. Comments from participants in Stage 2 of this research highlight the desire for Indigenous-led and focused connections: “I think we need to have our own, honestly.”

This led to conversations around cautions about collapsing Indigenous Peoples together with other equity-seeking groups, as is typical for equity, diversity, and inclusion initiatives. Numerous participants noted this to be an issue, noting that the profession cannot lump Indigenous health with equity, diversity and inclusion given the unique and harmful history between Indigenous Nations and settlers in Canada. Further, as detailed in Chapter 5 regarding ‘mitigating the asks’ in workplaces, some participants felt tired of telling people how to act in relation to working with Indigenous communities. For example, one participant said, “I’m so sick of telling people how not to act” whereas another participant indicated, “'When we come to this space, this is what we do. And this is what we don't do.' which is ridiculous to even have to like, tell people how to be in a space, but I know we do.” Although we, as a CoP, will likely still need to mitigate harm in

this space, providing opportunity for Indigenous-only conversation and collaboration inherently represents something different than telling settlers how to act when engaging with Indigenous Peoples and communities. Speaking back to colonialism infuses every moment of every day in our professional lives; we need time and space to talk amongst ourselves without that external focus. This will be further explored in the discussion.

Another key gap illuminated by participants in this sharing circle was the idea of Indigenous self-determination in OT. Currently, the OTIHN operates under the auspices of the national professional body CAOT, which means that the Network must operate via the rules, regulations, and procedures set out by CAOT leaders. At times, this means being unable to do things differently than they have been done. For example, one participant expressed concern about our ability to do the work in the ways we want to do it, if we remain as a Practice Network under CAOT: “See, that's the thing. We have good people doing this stuff, it's just that those systems are so fucking laden”. Another participant spoke about this as well, noting that, “The profession itself is so huge and problematic, that even us, who are trying to do good work, we're bogged down by that shit too.” These critiques inherently led to conversations around self-determination and our ability to branch away from already existing systems and create something that is representative of and directly responsive to the needs of Indigenous OT students and clinicians. Self-determination would allow us space for creative steps toward anti-colonial practice, if not decolonization.

This conversation naturally led to brainstorming around what the possibilities are for an Indigenous CoP. One participant noted that we could still remain connected to CAOT, but distance ourselves somewhat to ensure we have more control:

> "If we wanted to go a different route, and like, affiliate with CAOT, we can do that as a partner practice network, which is what the Occupational Justice for Newcomers Network did, because their membership disagreed with the processes at CAOT. So, they distanced themselves, and they're not, like, a formal practice network. CAOT has no say over what OJNN does. So, if we wanted to go that route, we could be a partner network."

Creating this Indigenous COP via an affiliation with CAOT has its perks whereby our CoP would be connected in ways with CAOT and be advertised in the OT schools across Canada and for marketing purposes, as one participant noted, however, even partnership Networks would nonetheless experience a lack of resources and support and would still be volunteer based. This discussion continued, however, and most participants ultimately felt this option did not fully meet our needs and desires for creating this space in the first place.

This led to agreement within the group that we would put our time and resources towards creating something new, from the ground up. One participant, when thinking about ownership over the work we plan to do, said it nicely:

> "Just 'cause I think we need to have ownership of what it is, where as we grow, we can change it. It's not like set in stone in how it looks, or what we need. It's

> going to change. So then we can change that, and not feel obligated to report back to CAOT."

However, despite agreement on doing something completely autonomous from our national association, this still led to concerns around funding and sustainability.

Sustainability

Indigenous specific supports and initiatives often are given time-limited funding, which is at risk of being cut and dismantled by overarching funding bodies. This was a concern for participants in this research:

> "Because, I think that, I worry about starting something outside of it, without sustainable funding. That is my biggest concern, because I don't want it to be something else that's off the side of whoever's running its desk. Which is what happens when there's no sustainable funding".

In thinking through this, the group noted that we could apply for small pockets of funding to get this CoP going, and then continually build the CoP toward something bigger and bigger. Not only does this allow us to take our time and do this work properly, it also provides demonstrated success (and need) over time. One participant suggested how we do this by saying, "It's like, seed funding, right? You get a little bit, and you're like 'Oh, this is what you can do. This is the outputs with that little bit of money. We'll give you more money' because it's showing that it's working." Other participants agreed with this idea and given the breadth and depth of expertise of Indigenous OTs at the table during this discussion, we all felt this would be something achievable.

Other participants suggested options to increase success and sustainability of an Indigenous CoP. In considering what other Indigenous-specific health professional organizations do across the country, the Indigenous Physicians Association of Canada (IPAC) was seen as a resource for us getting started. One participant noted that we could follow their lead and require a small membership fee from Indigenous OTs joining: "The other thing too, to consider, you guys, is that even maybe we pay a membership fee. Like, if the money, if there's funding, I would pay a membership fee, towards an Indigenous Network." This not only provides funding to create resources and supports within the Indigenous CoP, but it also creates buy-in for people to be invested and involved in what the CoP will be attempting to do over time. Another participant mentioned that there was an Indigenous pharmacists' association starting, and we could also reach out to those individuals and share ideas and resources on how to create a grassroots, Indigenous-led, initiative. This led to a broad brainstorming session around funding options, which included bodies such as the Social Sciences & Humanities Research Council (SSHRC), the Canadian Institutes for Health Research (CIHR), the National Indian Brotherhood, the Canadian Occupational Therapy Foundation (COTF) pockets of anti-racism funding that may be emerging, as well as reaching out to regulators and settler OT initiatives and individuals for support.

There was a general recognition among the group regarding the work required to do something autonomous, however, participants felt this was important, timely, and needed in OT if we are going to create better experiences for Indigenous students entering. Leading this on our own addresses cautions brought up by participants about

Indigenous initiatives being created quickly and without Indigenous input – which leads to doing more harm than good. Participants emphasized taking things slow, and intentionally, to not do things the wrong way or for the wrong reasons. The above sub-themes capture high level discussions as they relate to creating an Indigenous CoP in OT – I am now going to focus on key features noted by Indigenous OTs as essential to the creation of this CoP.

Key features of an Indigenous CoP

Indigenous OTs discussed key features of an Indigenous CoP that we felt are necessary. Below I will list in point-form some ideas generated and will follow with more contextual themes that emerged in order to create the activities proposed and desired for this Indigenous CoP. There was strong agreement within the group about these key features:

- Informal monthly meetings among Indigenous OT clinicians and students
- Salary for a formal Coordinator for the Indigenous CoP
- Elder involvement/funding for Elders
- Student supports, both to create community for Indigenous students as well as help them navigate post-secondary experiences within OT school and concerns or situations they may be experiencing.
- A list of questions that anyone wishing to engage with the CoP needs to consider and reflect on before asking anything of us. These would include (but not be limited to): considering the intent of the ask, time commitment, the benefit to Indigenous Peoples and communities, what funding is available, and so forth.

- Sharing the work of the Indigenous CoP widely. This includes publishing and presenting our work both nationally and internationally, pointing to the need for funding for open access fees. It would include creating a website that outlines our purpose, vision, mandate, as well as the parameters of our CoP to ensure we maintain a focus on Indigenous OT student and clinician supports. For example, one of the parameters would be that we would NOT offer cultural safety training for non-Indigenous Peoples.

The above-mentioned points capture some of the details, however, it is important to note that this Indigenous CoP will be continually evolving, and discussions on programming and activities will be ongoing, flexible, and context dependent. Below I capture higher level discussions of important details that complement the points above.

Capturing diversity of Nations and Peoples. Participants in this sharing circle spoke about their shared experiences being Indigenous therapists and working with Indigenous Peoples and communities across the country. From the Stage 1 storytelling sessions, OT5 noted how despite being an Indigenous OT, going into Indigenous communities that differed from their own specific Indigenous connection still left them feeling like an outsider lacking awareness of the specific Indigenous community and culture. For example, they spoke about how when working in other Indigenous communities that they were not a part of, they were unaware of the specific and unique ways of knowing, being, and doing in those communities. This idea trickled into the sharing circle discussions regarding ensuring representation and addressing diversity within the proposed Indigenous CoP.

In order to ensure we are not pan-Indigenizing experiences and needs across the country, many felt that we must be aware that what communities and Peoples need on the East Coast, for example, is likely very different than what is needed when working with Indigenous Peoples and communities in the North or the West. Therefore, there is a need to continually invite and expand this Indigenous CoP, while also understanding that despite all of us sharing common goals and desires to engage with an Indigenous CoP, we as a group will likely not all agree on one singular way forward in this work. One participant shared their thoughts on ensuring we are not pan-Indigenizing the needs of Indigenous OT students, clinicians, and communities, drawing on an analogy, saying no one expects all Europeans to be the same, we expect national differences, and in the same way Indigenous Peoples across Canada from different nations, territories and cultures will differ. That does not mean working together is impossible, or that there are no grounds for unity.

Maintaining a focus on whiteness and white supremacy was described as a way to ensure we are addressing colonialism and the often un-interrogated assumptions and norms that operate, rather than trying to explain in detail the diversity among Peoples and Nations. This includes being cautious about how we present the work we are doing. One participant shared that we should ensure we qualify this by saying, "From our collective experiences, what we do know is….." to ensure we are not misunderstood as speaking on behalf of all Indigenous people.

This led to further discussions about how we connect specifically with Indigenous communities across the country – something participants noted as a glaring gap in the OT

profession. For example, one participant noted that although we may be well positioned to connect with and begin considering how best to serve the needs of some communities, others may be more challenging to develop relationships with and address their unique health needs. Speaking about Northern communities they said:

> "They're already being impacted by it [climate change]. And like, just with melting glaciers and that too, and then, there's a lot of like, sickness in that ice too, that's been frozen there. So when it melts, it releases, so there's like, there could be new sicknesses coming out of that too. But they'll be the first ones to experience it."

Therefore, it is important that we think about how to connect with Inuit OTs in particular, if there are any currently in the profession. Doing this will strengthen our Indigenous CoP and also begin creating long-lasting and sustainable relationships to better understand the role of OT in Indigenous communities.

Despite these considerations, participants felt that we Indigenous OTs would be best positioned to be doing this work. One participant, in reflecting on our role in advancing Indigenous health across the country, said, "Well, we can use our power and our privilege, 'cause we do get assigned power and privileges with our title, you know? We could use that in a good way." This statement also captures the fact that although we may not know what is needed, we have the skills and abilities to do good work. This conversation lends itself well to the following theme that emerged, which centered around ensuring we are focusing on Indigenous excellence and the strengths of Indigenous students, clinicians, and communities.

Creating awareness of Indigenous excellence. Participants felt that it was important to highlight the unique contributions and skillsets that Indigenous OTs bring to the profession. This combats the frequently used deficit narrative when talking about Indigenous Peoples and Indigenous health broadly. This would not only push the profession forward to meet its commitment to address the TRC Calls to Action, but it also creates awareness among other Indigenous OTs who may not be aware that this Indigenous CoP is starting. One participant in the sharing circle stressed the importance of balancing critique with positive examples:

> "I would love to put forward different things that have worked and do feel good, and injecting a bit of like, joy, and success and Indigenous focused, like, brilliance and excellence and all those words that are used. But like, not always focusing on like, not the negatives to discount that, 'cause I know it's really important to point out the flaws for those to be changed, but I think also bringing like, how is what we knew or the ways that we do things also."

Participants then brainstormed on ways we could do this, which included creating a website for our Indigenous CoP and doing 'spotlights' on Indigenous clinicians that include all the amazing work being done. In order to do this, however, it is important to note that we would be asking Indigenous clinicians to speak with us and share details, and we would require website design and maintenance expertise, which are things that would require funding. This links to the sustainability issue discussed above highlights the need for funding in order to do the work we truly want to do. Further, in order to discuss and share Indigenous excellence broadly (with OT and beyond), there was a general

awareness that we must share our work through publishing and presenting, which is the following sub-theme.

Knowledge sharing. Given the diversity of experiences brought to this sharing circle, many of us had a wide variety of knowledge sharing ideas. Many felt that creating a formal 'landing space' or website would be the first step in sharing the work that is being done. Hiring an Indigenous web-designer and Indigenous artist to create a logo or graphic for the CoP was mentioned as a top priority by participants. Most of us felt it was important to find a balance between sharing this work in mainstream (settler colonial) spaces as well as supporting Indigenous journals, conferences, and other opportunities.

Other knowledge sharing ideas included: publishing in journals such as the *Canadian Journal of Occupational Therapy* (CJOT), *OT Now*, as well as other OT journals such as the *Brazilian Journal of Occupational Therapy* (BJOT); sharing some of our work in Indigenous specific journals such as the *Canadian Journal of Native Studies* or the *International Journal of Indigenous Health*; presenting at international conferences and developing relationships with Indigenous OTs internationally (e.g., Australia, Aotearoa, Brazil); liaising with CAOT and the regulators for each province (as a paid position); asking members to go out to Indigenous communities and sharing what OT is and what we do; creating relationships with OT schools across the country; as well as connecting specifically with other Indigenous OT Networks (e.g., the Māori OT Network) to see what has worked for them and to share ideas and needs. Beyond these ideas that were discussed, overall participants felt we must be creative and innovative in the ways in which we share our work, and that our approaches should come from our respective

Indigenous ways of knowing, being, and doing. One participant, in reflecting on our role sharing with institutions in particular, noted the following caution and way forward:

> "Instead of changing or trying to come up with a checklist of what institutions can do or what evidence-based practice in a certain community would look like, I think, it's almost like suggesting a different way of even thinking about things first, because you can't change a methodology before you change the epistemology."

This suggests the importance of not simply fitting our work into existing ways of doing things, and thinking about knowledge, but rather exploring new ways of doing based in Indigenous ways of knowing.

Importantly, a key feature of these discussions regarding knowledge sharing note that the ways in which we approach sharing our work must be intentional and collaboratively decided upon. Creating awareness of Indigenous OTs in the profession would feed into, and impact, possibilities for mentorship and support for Indigenous OTs and clinicians, which is the next sub-theme presented.

Mentorship and supports for Indigenous OT students and clinicians. All participants felt it was incredibly important to offer mentorship and support to Indigenous OT students and other clinicians. This was seen as a way to help mitigate some (but not all) of the negative experiences that participants in this research went through both in OT school and in their respective workplaces. Informal monthly meetings among Indigenous OTs and students were mentioned as a way to bring people into the work being done by this CoP. Others noted that we need to make ourselves visible and well known across all OT programs and ensure information about the CoP gets shared

with students at the onset of their programs. One participant highlighted the value of being affiliated with CAOT in some way to ensure that when all the practice Networks are shared with OT students, our Indigenous CoP is also shared. An idea that was brought forward was getting the OT schools to ask students whether they identify as Indigenous, and whether they would be interested in receiving mentorship from other Indigenous clinicians via checking a box on a form. If they desire mentorship, they could be formally connected with us to begin developing a relationship.

A few other important mentorship initiatives were discussed in this sharing circle, including bringing Indigenous OT students into conference presentations we are doing and involving them throughout the process; supporting Indigenous students who are making complaints or having negative experiences in their OT programs; as well as providing funding support in some way. Many participants shared their difficulties with paying for OT school given how expensive it is, so it was felt that long term, it would be ideal to offer small stipends or scholarships for Indigenous OT students through our Indigenous CoP. Further, hiring Indigenous OT students to do some work alongside us would be a good way to provide mentorship, facilitate co-learning, while also putting funds into the pockets of Indigenous OT students. It will be important to gather together again and continue these conversations as this would allow us to determine short- and long-term goals as well as map out important activities that we would like to create and offer throughout the years.

With a mandate to support Indigenous OT students, clinicians, and communities – discussion surrounding our role in supporting Indigenous health in OT broadly, as well as

engaging with settlers, emerged. The following sub-theme will capture this discussion, particularly around mitigating the 'asks'.

Engaging with settlers: Mitigating the 'asks'. Participants felt that to mitigate the 'asks' that come from settler OTs and organizations, that place seemingly relentless burden on Indigenous OTs, we must ensure we are clear on what the parameters of this Indigenous CoP are. Creating a website, as mentioned before, is one way of doing this, as one participant stated:

> "I think we need to be clear on what it is that we want to do and what it is that we don't do. So, when people come knocking at the door, it's like, 'You're going to have to go find that somewhere else.' or 'Here's some resources where you can go and (find that).'"

This also means that when we do receive requests individually (which, many participants noted are a regular occurrence for them), these should be sent to the group broadly to determine whether it is within our mandate. As mentioned above, we hope to develop and make available questions for people making requests to consider and engage with prior to coming to the Indigenous CoP with any 'asks'. One participant noted the importance of context: "'I need to know who you are, and what your stakes are in the game?' That's what I need to know from people," given the often-extractive nature of the 'asks', which usually offer little (to no) pay or other remuneration for our time. This highlights the need to shift from settlers guiding the work being done to advance Indigenous health towards protecting our time and our desire and ability to engage with

things that are meaningful to us. This chapter will finish with a focus on whether this Indigenous CoP has a role in providing recommendations for the OT profession.

Recommendations for the OT profession. Over the course of this research, ongoing conversations arose regarding whether we (as Indigenous clinicians) should be offering recommendations to the OT profession. Some of us felt we should be, as there was a general worry about not doing this and the consequences and potential harm that could ensue if we do not offer guidance. Others, however, felt that there are numerous resources available for the OT profession to draw from to create better relationships with Indigenous Peoples and Nations. Although we did not decide on a clear 'way forward' in relation to recommendations, many participants felt that we could use the TRC Task Force, which began in 2019, as a 'jumping off point' as one person explicitly noted. Another participant suggested: "They [the OT profession] have an obligation to respond to Truth and Reconciliation [Calls to Action], but they have to figure out how they're going to do that" which illuminates a gap, but also a caution for us as a CoP on whether this is (or should be) within our scope. There was agreement that the profession nationally needs to take action, and could benefit from the guidance of Indigenous OTs, but also acknowledgement that the time and energy available from a small number of Indigenous OTs could be drained meeting the needs of the (colonial settler) profession, leaving little to meet our own, self-defined needs and visions.

The conversation around our role in providing recommendations will continue as this Indigenous CoP moves forward. Importantly, however, one participant shared that "We all got together, then we're already showing that we're all on the same page. We're

all looking for similar ideas and space", and another participant continued to say "We're a collective" which highlights the power of what we're doing in this work.

Conclusion

This chapter detailed ongoing discussions amongst Indigenous OT participants on the need for an Indigenous CoP in the OT profession. Key ideas were generated through a sharing circle on this need as well as envisioning key features of this Indigenous CoP, including what we would (and would not) be doing in relation to Indigenous health and OT. Through a description of what Indigenous resources are already available in the profession, Indigenous OTs envisioned an Indigenous CoP through discussions of self-determination, sustainability, important key features, capturing diversity of Nations and Peoples in the CoP, illuminating Indigenous excellence, specific knowledge sharing ideas, the need to provide mentorship and support for Indigenous OT students and clinicians, and our ideas surrounding engaging with settlers. This chapter closes with a discussion on putting forward recommendations for the OT profession in Canada. All participants highlighted the need to be flexible and use a multi-pronged approach with numerous ideas and avenues for engagement as the best way forward. Supporting one another was mentioned as the key, most important feature of this Indigenous CoP, with recognition that knowledge sharing on our work would be essential for obtaining funding as well as continually growing this CoP across the country. These conversations will be ongoing as this Indigenous CoP gains traction in the coming years.

CHAPTER 8: DISCUSSION

This doctoral research aimed to explore the experiences of Indigenous occupational therapists in Canada. Findings capture our experiences in both OT post-secondary education programs as well as within clinical workplaces, with additional results in Chapters (3 and 4) capturing the extra work needed to create a sense of belonging and community. The research findings point clearly toward the timely creation of an Indigenous OT CoP. This chapter will be organized as follows: 1) A description of my study methods and their perceived influence; 2) An exploration of the nuances in the experiences of Indigenous OTs, in relation to my research objectives and compared and contrasted with the available evidence; 3) The profession's commitment to the TRC Calls to Action and how these relate to the findings of this research study as well as current trends in Indigenous health; 4) An interrogation of the Gaudry and Lorenz (2018) framework relating to the experiences shared by Indigenous OTs; 5) Indigenous sovereignty and self-determination across health professions and what can be learned to further support the creation of an Indigenous CoP, and finally; 6) An exploration of the use of Etuaptmumk in the OT profession to value, support, and privilege Indigenous students and their ways of knowing, being, and doing. Prior to moving into this discussion, it is important to conceptualize how the term Indigenous sovereignty is being used in this context. In this doctoral dissertation, I am drawing from the definition of Indigenous sovereignty provided by Bauder and Mueller in their 2023 paper whereby they contrast Westphalian and Indigenous sovereignty and how these terms are taken up. They note that "Indigenous sovereignty is thus not purely a legal source of political

authority, but rather a social and cultural way of defining community" (pg. 165). This is important given that the proposed Indigenous CoP outlined in this doctoral dissertation aims to create a self-determined[1] space for Indigenous OTs to form connections and community with one another. OTs involved in this study made it clear throughout that this was their overall collective goal.

Indigenous methodologies; the importance and impact

This research utilized Indigenous methodologies as a way to pay tribute to Indigenous methodologies and foreground Indigenous processes and protocols throughout this study.

This research employed Indigenous storywork (Archibald, 2008) for Stage 1 of this project and utilized the seven storywork principles throughout the research study. For example, respect was demonstrated through recognition of the privilege I have to be listening to these stories and having them shared with me. Indigenous OTs were able to make any edits to their stories after the session was transcribed, to respect their level of comfort in having those details captured in text. As this research is part of my doctoral study, I have a responsibility to listen deeply and learn from Indigenous OTs who participated in this work. This includes taking seriously the opinions, experiences, and considerations of Indigenous OTs who shared their stories with me, as well as being comfortable with changes in the research direction through following the lead of

[1] Self-determination is being used throughout this discussion to describe an Indigenous CoP that is decided by, and for, Indigenous OTs across the country. It notes our ability to control and make decisions regarding the Indigenous CoP that align with our goals, values, and objectives. It is viewed here as a component of moving towards Indigenous sovereignty for Indigenous OTs in this CoP.

Indigenous OTs who participated. Reciprocity is threaded throughout this work as it is my hope that this work will make a true difference in the lives of Indigenous OTs – including my commitment to continue developing an Indigenous CoP after this dissertation is complete. Reverence was shown to all Indigenous OTs who participated through relationality and links to how respect was at the forefront of this work, as mentioned above. This study aims to capture holism and interrelatedness through the presentation of the findings and paying tribute to doing this work from Indigenous worldviews and ways of knowing, being, and doing. Further, the sharing circle gathering emphasized the importance of gathering over food and drink, laugher, and even supported one Indigenous OT to bring her daughter with her to the gathering. Emotions and spirit were welcome, and this research further emphasized holism through inviting Indigenous OTs in and asking them to bring their own lives and their whole selves along with them in this work. Although this dissertation and the findings are presented in somewhat of a linear method, the findings have been carefully crafted to present the connections among themes, and chapters. Synergy of the stories shared, the context they are being used in, and the way the story is presented have been thought through thoroughly, with frequent checks in place with Indigenous OTs who participated to ensure they are being used appropriately.

A gathering followed in the Fall of 2022 which brought together Indigenous OTs from across the country to participate in a two-day sharing circle. This sharing circle gathering took place in an Indigenous space on campus equipped for smudging. Sharing circles have been used as a method of sharing information through respect and stories

for thousands of years (Lavallée, 2009) and allowed Indigenous OTs to be heard, hear on another, and create meaningful connections. Importantly, we had a Mi'kmaw Elder present to open the sharing circle in a good way. Further, what made a big difference was that she stayed and participated in the discussion as well, despite not being an OT herself. Elder Ann provided us with guidance and support, offered us strength and hope through the tears that inevitably came given the topics of discussion, and closed the sharing circle in a way that fostered connection and hope for our ongoing work together. The space and dynamics of this sharing circle are in line with a key feature of sharing circles – which is to provide a supportive environment for everyone participating to express their opinions, perspectives, and emotions without interruption (Rothe et al., 2009). Employing Indigenous methodologies that derive from Indigenous epistemologies provided an opportunity to create connection and shared understandings that I feel would not have been possible using Euro-Western methods. It is for this reason that the stories shared in this research are deeply meaningful and will create momentum for building community among us Indigenous OTs. What follows is an exploration of the experiences shared throughout this work, linking it to current evidence in OT and other health professions.

The experiences of Indigenous OTs: Considering the diversity and nuances

This study is the first of its kind in Canada, aiming to capture Indigenous OT experiences through post-secondary education and within their workplaces (Research Sub-Theme #1). Importantly, it also aims to advance an Indigenous CoP in the profession – something that has been called for by Indigenous OTs in recent years. Although there

are first-hand accounts of Indigenous OT student experiences (e.g., Valavaara, 2012; Clyne, 2023), there has been no empirical study capturing these experiences as well as bringing Indigenous OTs together to help foster community in the OT profession.

The experiences shared by Indigenous OTs in Canada throughout this study are aligned with previously published literature on Indigenous student experiences in post-secondary education (Gallop & Bastien, 2016; Gore; 2017; Pidgeon, 2008; Pidgeon et al., 2014) as well as within the health profession, specifically (e.g., Etowa et al., 2011; Pjil-Zieber & Hagen, 2011; Rimmer, 2011; Simpson, 2022; Smith et al., 2011). As described in the literature review, the health professions broadly have been relatively guarded, elite spaces (Beagan, 2005, 2007; Gorman & Sandfur, 2011) creating exclusionary conditions for those who do not fit a particular *mold*. Therefore, findings from this dissertation illuminate this context as ongoing and harmful for Indigenous learners. In their respective workplaces, Indigenous OTs' experiences also align with evidence emerging regarding the experiences of therapists from socially marginalized groups (Beagan 2005, 2007; Beagan & Chacala, 2012; Beagan et al., 2022; Beagan, Sibbald, Pride, & Bizzeth, 2022a/b/c; Hughes et al., 2021). Nonetheless, there are some important nuances to note within the data.

It is important not to pan-Indigenize and to pay respect to the diversity of Indigenous Peoples and Nations across Turtle Island (Caldwell, 2022), which was echoed in the findings of this doctoral study. Although many Indigenous OTs shared similar experiences in post-secondary OT programs, geography likely also plays a role in the unique experiences shared. For example, Indigenous OTs in this study from Western

Canada (e.g., British Columbia, Alberta, Saskatchewan) appear to have more front-facing Indigenous health supports in their universities compared to other OT programs. Many (but not all) post-secondary institutions in Western Canada are further advanced, at least at first glance, in terms of building relationships with Indigenous communities and supporting Indigenous students. Western Canada also simply has more capacity and more Indigenous scholars working in their post-secondary institutions, which likely plays a role in how Indigenous OTs experience their post-secondary education journeys. Importantly, although OT schools across the board are lacking Indigenous faculty and staff in their programs, students may find supports and shared experiences outside of their respective schools more easily in certain parts of the country compared to others. Therefore, if OT schools are not employing Indigenous faculty and staff, they should look to other units across their university to become aware of what Indigenous student supports are available, what Indigenous faculty are around, and so forth. These small efforts can make a substantial difference in the experiences of Indigenous OTs. For example, many universities have an Indigenous Student Centre, Elder supports, as well as targeted Indigenous initiatives that can be valuable for Indigenous OT students. Providing time at orientations, for example, to share these details, including bringing together Indigenous faculty from other units – would be small gestures that can make a big impact on the experiences of Indigenous OT students across the country.

Addressing Research Sub-Theme #4, the profession of occupational therapy is unique in that we are offered considerable flexibility in practice area and roles. Further, our profession boasts key concepts such as holism, principles of caring for kin, and it aims

to move away from the biomedical model towards a more wholesome picture of health and wellness through engaging in daily activities. Nonetheless, the profession is still derived from Western ways of seeing the world, and thus, although our profession holds promise for reconciliation and meaningful engagement with Indigenous Peoples, it remains relatively firm under the guise of Western ideologies. At the outset of this study, it was anticipated that Indigenous OTs employed in mainstream colonial institutions would have more difficulty finding belonging and experience more racism and discrimination due to their Indigeneity compared to those who work within Indigenous-specific organizations. Interestingly, data from this study suggest that this is not necessarily the case. Indigenous OTs in this study working in Indigenous organizations or communities often had experiences similar to those working in mainstream institutions (e.g., hospitals). The findings from this study show that many Indigenous OTs who work for Indigenous organizations and/or Indigenous communities still find themselves the only one or one of few Indigenous people employed, and still found themselves pulled towards abiding by and following colonial regulations, rules, and processes. In theorizing why this could be, some Indigenous OTs spoke about the fact that although they are employed by an Indigenous organization or community, these communities and organizations still operate through structures of colonialism and the federal government (for funding, in particular), and therefore, they are required to follow rules set out for them, which are often not decided by them. This finding is particularly important given that many Indigenous OTs in this study spoke about being excited to work specifically within Indigenous organizations, perhaps not realizing that they may encounter similar

barriers and difficulties to those encountered in mainstream institutions. Further, literature shows that connection to culture and opportunities to engage with those from similar cultural backgrounds (e.g., cultural continuity) can act as a buffer for handling situations of discrimination and racism (Auger, 2016; Currie et al., 2020) however, other factors are at play when it comes to understanding Indigenous OT experiences in their workplaces given the complexities presented by Indigenous OTs regarding working in Indigenous specific organizations and communities. This is a broader issue than can be thoroughly explored in this study, however, this discussion point will be continued when exploring Indigenous sovereignty and self-determination later in this discussion.

In relation to being an Indigenous OT in any space, the notion of passing as the 'right' kind of minority emerged in both the education and workplace experiences chapters, albeit indirectly (Research Sub-Theme 1 and 3). Passing as the 'right' kind of minority means that although you are a minority in a particular space, you are someone who does not 'rock the boat' too much, or raise issues for the institution to deal with. Effectively, being the 'right' kind of minority feeds into the assimilatory nature of post-secondary institutions (Jenkins et al., 2021; Martimiankis et al, 2009), meaning that they'd like to admit students from marginalized groups, but feel safest when these individuals come in, sit down, and shut up. In post-secondary OT education programs, some OTs in this study described needing to put their head down and not openly identify as an Indigenous person; whereas others very openly identified and spoke out actively regarding Indigenous inequities and their own experiences of racism and discrimination in their OT programs. Both ways of getting through OT school are valid, and are

dependent on the individual and their choice to selectively disclose Indigenous identity. For some, being white-presenting and having the ability to selectively disclose their identity can be an advantage to mitigate discrimination and racism (Reid & Pride, 2023), whereas others do not have that option due to their outward appearance. However, we must always bring this back to the underlying reasons why individuals feel the need to hide their identity in the first place. This is a systemic problem, not an individual problem. It is rooted in colonialism and anti-Indigenous racism, not in Indigeneity.

These experiences are in line with those of other marginalized therapists in the health professions (Beagan, Bizzeth, et al., 2022; Beagan, Sibbald, et al., 2023; Bizzeth & Beagan, 2023). It leads to a broader discussion of the reasons some Indigenous Peoples do not feel safe to disclose Indigenous identity in certain spaces. Nonetheless, in the health professions those who are able to 'pass' as a member of dominant Euro-Western groups may choose to do so for various reasons. As Sara Ahmed argued in her book *On Being Included (2012)*, "the need to legitimize your existence can require that you actively reduce rather than increase your visibility" (pg. 157) which may act as a safety mechanism for certain individuals. These findings are incredibly important as OT schools actively aim to recruit and retain more Indigenous students, yet, this research shows that for those who do enter OT programs, their experiences are overwhelmingly negative.

Finally, it was anticipated (perhaps naively) that Indigenous OTs who graduated several years ago would have reported having less Indigenous content in their education experience, and worse experiences in OT programs and OT workplaces. Indigenous OTs in this study graduated between 2005-2021, yet, there were remarkable similarities in

experiences for those who graduated 15+ years ago and those who graduated recently. Although many who graduated recently did report more Indigenous content, the ways in which the content is being created, integrated, and taught, played an important role in the experiences of Indigenous OTs as well. Many newly graduated Indigenous OTs spoke about still being the only one, or one of few in their programs, as well as needing to flip back and forth between 'jagged worldviews colliding' to succeed in OT school. This is in line with literature in the health professions that has been published in the last 10+ years (Conway & Hicks, 2019; Etowa et al., 2011; Martin & Seguire, 2013; Pjil-Zieber & Hagen, 2011; Rimmer, 2011; Simpson, 2022; Slayter et al., 2016; Smith et al., 2011), which highlights little change to Indigenous student experiences despite a surge in efforts. Many Indigenous OTs in this study graduated after the TRC released their final report in 2015 (TRC, 2015a), and therefore, one would imagine an improvement in experience for Indigenous learners. What follows is a critical exploration of some prevalent TRC Calls to Action and how they relate to the current context of the occupational therapy profession *in Canada.*

The TRC Calls to Action and occupational therapy

The Truth and Reconciliation Commission of Canada and the completion of their inquiry in 2015 was influential across the country in relation to Indigenous health and wellbeing. Their Calls to Action, also released in 2015, are intended to be actionable items across various important sectors that have direct impacts on the health and wellbeing of Indigenous Peoples (TRC, 2015b). My decision to deliberately lay out particularly prominent calls to action and link them explicitly to the findings of this

research emerged from published literature from Indigenous scholars discussing the lack of a concrete definition of reconciliation and how it is taken up differently in different spaces (O'Neil, 2020). By not having this clarity, reconciliation efforts can be slowed or diverted by engaging in activities or opportunities that do not represent the goals, values, and priorities set out by Indigenous Peoples themselves. Or, even worse, lack of clarity can halt progress entirely (George, 2020). Further, as of 2022, only 13 TRC Calls to Action have been addressed (Jewell & Mosby, 2022). They note that "At this rate, it will take 42 years, or until 2065, to complete all the Calls to Action" (pg. 5). Therefore, by linking specific TRC Calls to Action with the findings of this dissertation, it is hoped that this framing will result in meaningful progress and action.

Although many of the TRC Calls to Action are important in the context of this doctoral study, a few of them are particularly relevant and support further exploration based on the findings presented here. These Calls can be divided into Indigenous health (broadly), and Indigenous health in relation to post-secondary education.

TRC Calls to Action pertaining to Indigenous health (broadly):

- Call #18: We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties (pg. 2).

- Call #19: We call upon the federal government, in consultation with Aboriginal Peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services (pgs. 2/3).
- Call #22: We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients (pg. 3).

Calls to action pertaining to Indigenous health in post-secondary education:

- Call #10: We call on the federal government to draft new Aboriginal education legislation with the full participation and informed consent of Aboriginal Peoples. The new legislation would include a commitment to sufficient funding and would incorporate the following principles (pg. 2):
    - i. Providing sufficient funding to close identified educational achievement gaps within one generation.
    - ii. Improving education attainment levels and success rates.
    - iii. Developing culturally appropriate curricula.
- Call #23: We call upon all levels of government to (pg. 3):

    - i. Increase the number of Aboriginal professionals working in the health-care field.
    - ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
    - iii. Provide cultural competency training for all healthcare professionals.
- Call #24: We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism" (pg. 3).

The profession of occupational therapy in Canada has declared its commitment to addressing the TRC Calls to Action (e.g., ACOTRO, 2022; CAOT, 2016a; Gerlach et al., 2018b), yet findings from this research demonstrate that the profession has a long way to go before living up to that commitment. For example – in order begin fulfilling Call #18 regarding the roots of health inequities, these understandings of Indigenous health must be displayed at every level of post-secondary education for non-Indigenous students to begin grappling with the causes and contexts of Indigenous health outcomes in Canada. This means occupational therapy schools across Canada have a responsibility to ensure not only their students, but also the faculty and staff they employ, have been educated on, and understand, the root causes of Indigenous health inequities.

Given that most Indigenous OT students in this research felt excluded, a lack of support, a devaluing of their merit and skill in OT, having to operate between two worldviews, and felt as though OT is perpetuating cultural imperialism, I argue that there is a lack of recognition and awareness of Indigenous Peoples and our ways of knowing, being, and doing in the context of Euro-Western dominance. Further, this can be related to a lack of understanding of Indigenous health, and subsequently Indigenous health inequities via examples from OTs in this study not being afforded flexibility to care for families, attend to community crises, and engage in Indigenous specific ways of doing such as ceremonies or gatherings. Given the experiences of OTs in this study, it is clear that these discussions are not being well integrated into most OT programs across Canada.

In order to move this Call to Action forward in OT, we must take guidance from Indigenous OTs and OT students as well as Indigenous communities in ways to ensure this is taken up meaningfully within our programs as well as broadly, in our health care systems. By taking the lead from Indigenous Peoples, the OT profession would be aligning itself with best practices emerging from Indigenous health literature, as well as supporting Indigenous sovereignty and self-determination, which was heavily emphasized in conversations regarding an Indigenous CoP in OT.

In exploring our ability to begin addressing Call #19 regarding closing gaps in health outcomes, there has been a call for better data on Indigenous health indicators (Rice et al., 2023) broadly, as well as from OT scholars specifically (Gerlach, 2018a; Gerlach et al., 2022) to begin addressing gaps that communities know are there. Given

that it is also well documented in Indigenous health literature, as well as literature specific to OT, that we must do things differently when working alongside Indigenous Peoples and communities (Emery-Whittington, 2021; Gerlach, 2018a; Gibson, 2020; Hunter & Pride, 2021; Pilarinos et al., 2023; Price & Pride, 2023; Reichert et al., 2023; Ryall et al., 2021; White & Beagan, 2020), we first must make space for Indigenous OTs to enter and succeed in OT programs, and then we must ensure retention within the profession for us to lead this important work, as well continually build capacity. For far too long, Indigenous health and subsequently Indigenous health inequities have been researched by non-Indigenous Peoples with little benefit leading to meaningful change within communities (Mosby, 2013). The OT profession has an opportunity to be leaders in the health professions by way of supporting meaningful, needed, and *community-driven* research.

One can argue that although Call #24 focuses on medical and nursing schools needing mandatory courses on Indigenous health, OTs should pay close attention to our need to do the same in this regard. Further, the ability for the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in working with Aboriginal patients, in collaboration with Aboriginal healers and Elders (Call #22) is contingent on all health professions doing important work in their own spheres to enact change. Findings from this doctoral study demonstrate that within many Masters of OT programs, these topics are lacking, and students are taught practice approaches that contradict these Calls to Action. Indigenous OTs reported that Indigenous health content in general may be touched on briefly, offered as an 'optional' course, or missing entirely.

This is a glaring gap that must be addressed if we expect OTs to graduate able to understand how best to support Indigenous clients they will encounter, and if we wish to optimize the likelihood that Indigenous OTs and students will find a sense of belonging within the profession. This connects to the need for educational content that is culturally safer than what is currently being taught (Call #10 and Call #24), and also heavily impacts the educational success and attainment of Indigenous Peoples across the country (Call #10).

One major barrier that all health programs are encountering is a lack of capacity to make these meaningful changes. From a progress standpoint, one can get bogged down with the need to better recruit and retain Indigenous students (Call #23), while also needing more Indigenous faculty and staff to support Indigenous students once they are in these programs. This is compounded by the need to also provide cultural competency training for non-Indigenous students, faculty, and staff, as outlined in the TRC Call to Action #23. In their 2023 article, Pilarinos et al. share ways of improving current cultural safety practices to improve Indigenous patient experiences. At the same time, however, research drawing on interviews with Indigenous cultural safety facilitators illuminates the unsafe environments and burnout they experience when running these programs (Erb & Loppie, 2023). Further, there are drawbacks to mandatory Indigenous health courses relating to the attitudes and perceptions of learners (Melro, Matheson & Bombay, 2023). Melro, as part of her doctoral dissertation, explored impacts on attitudes towards Indigenous Peoples after taking a required Indigenous health course in post-secondary education. She included a total of 335 learners across three cohorts. Importantly, only

one cohort reported any change following the intervention (e.g., the Indigenous health course), however, in the 2020 cohort, this study did find that learners were more likely to believe that historical factors contributed to present day inequities for Indigenous Peoples. Interestingly, in the same cohort, this study found that individuals who are already less willing to acknowledge or recognize their own role in the factors contributing to health inequities, there was an increase in blaming attitudes and less support for action on behalf of the government to support Indigenous Peoples. These findings are incredibly important and illuminate the unexpected negative effects (Melro, Matheson, & Bombay, 2023) that these courses can have. However, it is also important to note that the study did not report the qualitative components of this work, which likely would provide a different view of mandatory Indigenous health courses in post-secondary education. As we grapple with the need to have Indigenous health content embedded into OT programs, these findings illuminate our need to not only have the content there, but be critical in how it is presented, and how we evaluate its' success, while ensuring we keep Indigenous people safe who are presenting and sharing this work. It would be naive to consider these easy problems to solve – however, with guidance from Indigenous OTs already in the profession, this study aimed to illuminate what we have done and what we can do as a profession to better support Indigenous OTs, Indigenous students, and Indigenous communities to access the full potential of what OTs can do.

Indigenous inclusion, reconciliation Indigenization, and decolonial Indigenization: What can OT learn?

Our ability as a profession to begin addressing the TRC Calls to Action and moving towards reconciliation is contingent on numerous systems operating in concert with one another to enact meaningful change based on the identified needs of the communit(ies) we aim to support. Literature outside of the health professions, most notably literature written by Indigenous scholars aiming to shed light on needed changes for reconciliation, can be helpful; it may benefit the OT profession to more openly engage with such external research and areas of inquiry. As outlined earlier in this dissertation, Gaudry and Lorenz (2018) have published a helpful framework to both critique and guide post-secondary institutions in their reconciliation efforts. As one participant mentioned in this study, "Critique is necessary for advancement" which leads us to consider how efforts within OT fall along the continuum from Indigenization to decolonization (Research Sub-Theme #5).

Gaudry and Lorenz's (2018) framework on Indigenous inclusion, reconciliation Indigenization, and decolonial Indigenization note varying levels of effort relating to Indigenization and decolonization in post-secondary institutions. Much of the literature explored at the beginning of this dissertation might be categorized as Indigenous inclusion, which Gaudry and Lorenz describe as increasing Indigenous participation within existing structures. Some would be described as reconciliation Indigenization, bringing together Indigenous and Euro-Western knowledges to develop new understandings and further relationship-building. Notably, decolonial Indigenization, complete transformation of power relations and institutional structures, was not something that was occurring – yet the language of decolonization is being widely used by post-

secondary institutions in Canada, despite not meeting its true intent, as set out by Smith (2012). Tuck and Yang (2012) caution that we must not consider decolonization as a metaphor – we must be intentional, understand its meaning, and support Indigenous-led decision making and expertise. Many scholars have described what is needed for decolonization (Battiste, 2017; Smith, 2012; Tuck & Yang, 2014). Some have also noted, however, the tension of post-secondary institutions deeming decolonization too radical to accomplish (Gaudry & Lorenz, 2018). One is left wondering whether we can truly decolonize systems built on colonial ideologies, practices and hierarchies. Of course, this question remains relevant to OT. First, though, a critique of what is currently happening in OT – mainly Indigenous inclusion.

All of the Indigenous OT participants in this study felt that efforts within their respective OT programs in Canada fell into the Indigenous inclusion category, meaning the 'add and stir' approach (Battiste, 2017). However, even when they felt that efforts at inclusion were happening, many still felt there were glaring concerns regarding the ways Indigenous content was being included. Many noted that what was being incorporated was inappropriate, not derived from Indigenous Peoples themselves, or, for some, they did not have any Indigenous content in their programs. This speaks to three points of inquiry: 1) How do we ensure Indigenous content being incorporated into OT programs is deeply considered, using methods carefully and deliberately chosen?; 2) In the absence of Indigenous faculty in OT programs, what do we do with the findings that insist Indigenous Peoples deliver Indigenous content?; and 3) How do we move past

Indigenous inclusion towards reconciliation and decolonial Indigenization, as envisioned by Gaudry and Lorenz (2018)?

Notably, the lack of guidance on how to meaningfully incorporate Indigenous content was evident across OT programs. Efforts to create and incorporate Indigenous curricula are moving ahead, due to the profession's need to do so and professed commitment to addressing the TRC Calls to Action, however, many are moving ahead without appropriate consultation, which is evidenced by experiences shared by participants when they attended OT school. Historically, this has been done over and over again to Indigenous Peoples (Mosby, 2013; Oudshoorn, 2019) and often does more harm than good, despite the best of intentions. These efforts to move forward with new Indigenous content are many times done with no Indigenous input, or efforts are made to incorporate Indigenous community input without also having Indigenous OT input – both are important in this work. If we understand that Indigenous communities must be actively involved and consulted in all efforts that have a direct impact on us (Murphy et al., 2021), then moving forward with curriculum changes without appropriate consultation can cause great harm and continue to perpetuate colonialism. What is evident from these findings is that Indigenous OTs are well-positioned to be leading this national effort, however, they are often not being systemically called upon to do so. This consultation work must be done, and it cannot be done for free. If the profession truly wants to develop meaningful ways forward to address the TRC Calls to Action, an appropriate starting point is to draw on the expertise already present in the profession. This means that Indigenous OTs should be approached for their thoughts on this work,

and taken seriously when they question methods or processes, given our expertise. These efforts cannot be done under the guise of 'business as usual' and is one of the contextual factors driving forward a call for an Indigenous CoP to be created, so Indigenous OTs can be part of a collective and contribute meaningfully to improving Indigenous health and occupational therapy.

Although many of us involved with this study are observing increasing numbers of Indigenous OTs graduating from OT program as many of us teach in OT programs, the number of Indigenous OTs who hold, or who are pursuing a PhD is still few and far between. Post-secondary institutions across the country are grappling with the need to hire and retain Indigenous faculty and staff, so it is unsurprising that the profession of OT is no exception to this. A question that emerged frequently in this study is what the profession should be doing, in the absence of having Indigenous faculty in OT to support this work. I believe this research, and most notably, an Indigenous CoP, can play a key role in filling this gap, however, a few important points must be made. The goal of the Indigenous CoP will not be primarily consulting – it will be to support Indigenous OT students and clinicians throughout their educational journey and into their careers. It is intended to be a space by us, and for us. Notably, there is a tension here – given that Indigenous OTs recognize the need for these things to improve the profession overall, yet we must also hone in and focus on our own Indigenous CoP and the needs of Indigenous OTs specifically. Nonetheless, being a group with diverse and unique expertise, we envisioned that being involved in these conversations would be important, and necessary. It will, of course, further support Indigenous students in OT programs to feel

as though they belong, and that the curriculum being taught and integrated is relevant, meaningful, and appropriate.

Another point of discussion centres around the assumption that all Indigenous People can teach all Indigenous content. This assumption is problematic in and of itself and does a disservice to the diversity of Indigenous Nations and Peoples. OT schools across the country must not assume that all Indigenous content can be given to a single Indigenous faculty member, as this would be inappropriate. Instead, OT schools should aim to hire Indigenous faculty, but also create relationships with other Indigenous units on campus, as well as local Indigenous communities. These efforts, happening in tandem with one another, will begin to ensure that changes being made to *Indigenize* are not harmful, at the very least, and may even be helpful and appropriate. This is also where an Indigenous CoP in the profession can fill a gap. Given the diversity of members already involved in this proposed CoP, the experiences present can help to ensure that work being done is not pan-Indigenous in nature and is appropriate for local contexts as well. Therefore, a standardized national curriculum on Indigenous health would do little justice to the diversity present in each of the locations where OT schools operate, and therefore, it is best to begin this work by collaborating with local Indigenous communities, organizations, and Peoples, including Indigenous OTs from that territory. This final point connects to the following section focused on Indigenous self-determination and sovereignty.

Indigenous sovereignty and self-determination in occupational therapy

In response to efforts put forward by Indigenous Peoples and Nations, calls for sovereignty and subsequently, self-determination have never been more prevalent. Indigenous Peoples and communities must be in control over our lives, in virtually every system, with post-secondary institutions and health care institutions being at the forefront of calls for change. As an example of this, many Indigenous communities are taking control over their own research agendas and calling for research to be done by us, with us, and, in some instances, for us (Bull, 2010; Dadich, 2019; Smith, 2018). This relates directly to Indigenization, reconciliation, and decolonization efforts in post-secondary institutions, which require active collaboration and engagement with Indigenous Peoples and communities before making changes that directly impact them (Chilisa, 2019; George, 2019; Murphy et al., 2021). Pertaining to health services, we have seen a surge of Indigenous health authorities emerging globally (e.g., Māori health services being established in Aotearoa noted by Gilsenen, Hopkirk and Emery-Whittington [2012] and in Canada [e.g., the First Nations Health Authority in BC, and Tajikeimɨk in Mi'kma'ki]). Occupational therapy is part of both post-secondary education and the health care system, and therefore, must also contend with the need to support Indigenous sovereignty and self-determination in the profession.

Literature pertaining to working with Indigenous communities in occupational therapy is limited. However, it is well established that we cannot continue to operate the same methods, procedures, assessments, and criteria taught in OT school in Indigenous contexts (see, for example, Gerlach, 2018a; Hunter & Pride, 2021; Price & Pride, 2023; White & Beagan, 2021). In the Canadian context, Alison Gerlach has been doing work

with Indigenous children (Gerlach, 2018a) and more recently, autism in Indigenous communities (Gerlach et al., 2022). Janna MacLachlan (2010) has detailed needing to modify standard OT practices when working in the North with Inuit communities. Further work is attempting to identify gaps in Indigenous knowledge in OT (see Jacek et al., 2023) as well as capture information on Indigenous Peoples and OT broadly (see Bauer et al., 2023). These research studies illuminate the need to modify our practice when working with Indigenous Peoples. The ability to take standard occupational therapy practices and modify them to suit the needs and desires of Indigenous Peoples requires both skill and experience and is something that has been almost entirely absent from OT programs. This issue is compounded by the fact that research coming out (such as Gerlach, MacLachlan, and others) takes an exceedingly long time to be taken up in curriculum and health professions programming. This is in line with the experiences shared by Indigenous OTs in this study that they felt ill-equipped to take what they learn in OT school and apply it when working within Indigenous communities. They noted repeatedly that they were not taught how to work in Indigenous contexts, which is a glaring gap in curricula and professional development.

Beginning in 2009, the Occupational Therapy and Indigenous Health Network (OTIHN) has attempted to fill this gap. This Network has been co-chaired by two Indigenous occupational therapists who are locally, nationally, and internationally known in the OT community for their efforts relating to critiquing colonialism and white supremacy, while advancing the TRC. Since its inception, this Network has been one where Indigenous and non-Indigenous OTs can gather and discuss important needs

within the profession and share knowledge related to working with Indigenous communities. However, the OTIHN is officially ending in September 2023, with its final meeting happening mid-September, and CAOT is exploring how they are going to fill in the gap(s) left from the ending of the OTIHN. Nonetheless, given the increase in Indigenous OTs in the profession since 2009, it is becoming clear that Indigenous OTs require a safe space for us to support one another and create a community that is Indigenous-led and Indigenous-specific. Therefore, although this Network has served a particularly important purpose, we are in a place and time where the current structure does not support Indigenous sovereignty and rights. We need to create something that is by us and for us: an Indigenous OT CoP.

The push for an Indigenous CoP in OT is not dissimilar to what is happening in other health professions. Physicians have created the Indigenous Physicians Association of Canada (IPAC) which describes their vision as "Healthy and vibrant Indigenous nations, communities, families and individuals – supported by Indigenous physicians and others who are contributing to the physical, mental, emotional and spiritual well-being of our people and having a positive impact on the social determinants of Indigenous health" (Indigenous Physicians Association of Canada, 2023, para 1). This association has staff, student supports, advocacy work, as well as awards given out to Indigenous physicians in Canada. The nursing profession has created the Canadian Indigenous Nurses Association (CINA), which began its groundwork back in 1974. Their website outlines key objectives, many of which are values and goals mentioned by Indigenous OTs in this study, such as, "To work with communities, health professionals and government institutions on

Indigenous Health Nursing issues and practices within the Canadian Health system that address particular interest and concern in Indigenous communities with a view to benefiting Indigenous Peoples of Canada by improving their health and well-being, physically, mentally, socially and spiritually" (Canadian Indigenous Nurses Association, 2019, para. 6). The OT profession can learn a lot from what other health professions are doing and can be leaders in supporting Indigenous students and communities through the creation of an Indigenous CoP. Work toward the creation of this Indigenous CoP has been ongoing (White et al., 2021) and this doctoral dissertation has been one avenue to get this work off the ground despite Indigenous clinicians and scholars being overwhelmed with other work they are required to do.

By creating a self-governed and self-determined Indigenous CoP in OT, not only will Indigenous OT students and clinicians be brought into a space that is designed specifically for them, but they will also ideally benefit and gain supports and knowledge that are not otherwise always available to them in their post-secondary OT journeys. The decision to create an Indigenous CoP outside of CAOT Practice Networks supports the need for Indigenous OTs to be able to determine what works, what does not, and carve a path forward that is representative of Indigenous values and ways of knowing, being, and doing. This brings us closer to what Gaudry and Lorenz (2018) conceptualize on their spectrum of Indigenous inclusion to decolonial Indigenization. By being externally funded, it also responds to recent literature critiquing whether reconciliation is truly benefitting Indigenous Peoples, or whether reconciliation is truly the desired end goal of Indigenous Peoples in the way it is being framed, often by government (Simpson, 2016).

This Indigenous CoP will allow us to do and decide things on our own terms, utilizing Indigenous knowledge systems at the forefront, and emphasizing the need for Indigenous-led work in the OT profession. Moving toward recognition of Indigenous sovereignty through a self-determined and self-governed CoP is moving along the continuum away from 'add and stir' Indigenous inclusion toward decolonizing (Gaudry & Lorenz, 2018).

Addressing Research Sub-Theme #2, this dissertation closes with an exploration of the guiding principle of Etuaptmumk, put forward originally by Elders Albert and Murdena Marshall, and Cheryl Bartlett (Bartlett, Marshall, & Marshall, 2012) with the support of Charlie Labrador, Mi'kmaw Spiritual Leader, healer, and Chief of Acadia First Nation. Discussions on Indigenous sovereignty, rights, and self-determination are incredibly important; however, we must also grapple with how best to use multiple perspectives in occupational therapy for the betterment of all – those who we aim to work with as clients, and those who are employed as OTs across the country. Occupational therapy is grounded in colonial (Western) ideologies and ways of doing, and thus, Indigenous OTs will continually need to engage with this as we aim to also bring our whole selves and our Indigenous knowledges into the profession.

Etuaptmumk and the need for multiple perspectives in occupational therapy

Recently, the OT profession has begun grappling with how best to draw in other ways of knowing, being, and doing to inform where the profession is going. This is evidenced in new work emerging from Kiepek (2023) regarding the use of Indigenous knowledges, as well as recent papers critiquing OT assessments (MacLachlan, Phenix &

Valavaara, 2019; Price & Pride, 2023) and frameworks (Hunter & Pride, 2021). This work is difficult, given the privileging of Western (white) ways of seeing the world (White & Beagan, 2020) and white supremacy (Grenier, 2020) that is infused into the profession. Although not directly discussed in Bartlett, Marshall and Marshall (2012), the guiding principle of Etuaptmumk inherently asks the dominan Euro-Western population in society (mainly, white settlers) to relinquish some of the power and monopoly they have held for decades over knowledge systems and institutions and humbly consider that their way of doing something is not necessarily the right way, or the wrong way, it is just one way. By forcing others to assimilate into one way of seeing the world, we do a great disservice to our ability, collectively, to be able to tackle the biggest problems facing our society and our planet today. Thus, this is a call for OT to welcome input, critique, and change for the sake of all – not just Indigenous Peoples and communities. This is a call for the OT profession to see with two eyes, to take up the strengths of different ways of seeing and knowing, for the betterment of all.

Through this work, Indigenous OTs have contributed and shared their unique knowledges and skill sets without the profession paying respect to that. We must all work together to understand that Indigenous ways CAN, and SHOULD, contribute to the OT profession. We were, and are, the rightful stewards of this land and have survived and thrived on Turtle Island for centuries. At times, Indigenous knowledge is categorized as primitive, unscientific, and less valid (Marker, 2004; Martin, 2012; Kuokkanen, 2008), yet our abilities to adapt to change, survive, and thrive, are nonetheless evidenced daily. Our knowledge systems and our people can, and should, be drawn upon actively in a

profession such as OT, where we are attempting to support diverse populations across huge geographical space.

Interestingly, although Indigenous OTs did not necessarily use the term Etuaptmumk, all of them engaged in a back and forth between worldviews and perspectives during their OT training or OT practice. This is something that as Indigenous Peoples living in a society dominated by a Western colonial ideologies, we are accustomed to doing and required to do in order to engage with mainstream spaces. Simply put, this is something that we are now asking settlers to do. Notably, we are not asking settlers to become experts in Indigenous knowledges, as this is not possible, however, we are asking that the valuing, and consideration, and space for other ways of knowing, being, and doing, become a way of engaging, just as it has been for Indigenous people since time immemorial. Prior to ending this chapter, I wanted to share a quote from the newly published book "Indigenous resurgence in an age of reconciliation" edited by Heidi Kiiwetinepinesiik Stark, Aimée Craft and Hōkūlani K. Aikau, that outlines beautifully our need to expand our minds toward other perspectives:

> "When Western scientific knowledge fails to provide insights for how to live in a precarious world affected by devastating natural events such as earthquakes and tsunamis, attention will be given to Indigenous knowledge systems, recognizing that Indigenous Peoples have had to contend with these concerns since time immemorial. Yet, even when Western thinkers are willing to consider the stories that detail these historic events that are absent from the Western historical record, they often fail to give consideration to how Indigenous knowledges posit

> we are a part of the web of relationships that give rise to these moments. Instead, Western divisions between human and nature are reified even while considering the Indigenous stories that work against this categorization and binary by detailing the interconnectedness of Creation. These tendencies minimize or contain the transformative potential of Indigenous knowledge, rendering it easier to incorporate and assimilate into Western categories of knowledge. It is not enough to make space for Indigenous knowledge. We must allow for this space to be reconfigured by Indigenous knowledge" (Kiiwetinepinesiik Stark, 2023, pg. 14).

The profession of OT can and should be changed, reconfigured, and strengthened by Indigenous knowledges. It can and should draw directly from the expertise of Indigenous students and clinicians, reconfiguring OT into something new, something improved for all. That is the transformation demanded by decolonial literature illuminating the need to move beyond mere Indigenous inclusion in already existing systems towards changes that support reconciliation and acts of decolonization. This would truly mean the valuing of multiple perspectives, which is at the core of Etuaptmumk as a guiding principle.

Strengths and Limitations

This research study aimed to work alongside Indigenous OTs across the country to capture their experiences in both OT school and OT practice, as well as creating meaningful connection and collaboration to move forward an Indigenous CoP. Rather than speaking to the conventional markers of trustworthiness in qualitative research (e.g., transferability, credibility, confirmability, dependability), I wish to emphasize the ways in which this work was deeply collaborative in nature and underpinned by principles

of respect, responsibility, reciprocity, and mutuality. Indigenous OTs in this research were much more than sources of 'data' in that they supported in creating, direction, and overall analyses of this work. For myself, this work has been a means of connecting and collaborating on shared goals and objectives and has already begun the creation community for Indigenous OTs in the profession in Canada. For example, some of this work was co-presented at the 2023 CAOT conference, where I was able to also meet with Indigenous OTs prior to the conference and gain valuable feedback and direction on my dissertation. We had the opportunity to gather, laugh, eat, and share – which has always been important to me. This dissertation would not have been possible without the support and love Indigenous OTs who were involved have given me, and each other.

It is important to also acknowledge the limitations of this research study. This study was limited in its ability to deeply explore the nuances pertaining to Indigenous experiences, most notably related to the diversity among Indigenous identities, year of graduation, geographical context, as well as current and previous practice areas. Given that this is the first study of its kind capturing Indigenous OT experiences in Canada, further research should be done to explore more deeply the impacts and contextual factors that play a role in ones' experience as an Indigenous OT student and clinician. Further, this study captured a small portion of the Indigenous OT population, and therefore, future research should aim to explore experiences of other Indigenous OTs not captured in this work to continually contribute to this much needed literature base. Finally, this study critiqued the ways in which Indigenous knowledges are being taken up in post-secondary OT programs across the country, however, providing concrete

solutions and ways forward was not at the forefront of this work. Further research should aim to capture how OT schools are doing this work, what consultations are being done, and explore best practices for ensuring Indigenous content being added is helpful, culturally and locally relevant, as well as supported by Indigenous Peoples and communities in the area.

Practical Implications

This study has numerous practical implications. The following were chosen as key implications to highlight:

1. Despite the OT profession aiming to recruit and retain more Indigenous students and clinicians, little work is being done to ensure efforts being put forward are appropriate, culturally relevant, and not harmful to those they are intending to support.
2. Gathering expertise, advice, and knowledge from Indigenous OTs who are in the profession or who are being educated in OT programs should be a first step towards developing Indigenous curricula.
3. The profession must resist attempting to fit Indigenous knowledges into already existing Western systems and processes and instead, welcome and be open to allowing the profession to be changed by Indigenous knowledges.
4. The OT profession can learn a lot from other health professions who have created their own Indigenous Networks to support both Indigenous clinicians in those respective professions as well as move forward on how best to support Indigenous Nations, communities, and Peoples.

5. The OT profession must work to develop and research, alongside Indigenous Nations, communities, and Peoples, how OT can, and should, be working within Indigenous contexts. This research must privilege and capture first-hand accounts from Indigenous Peoples directly.

Conclusion

This study utilized Indigenous storywork and sharing circles to gather insight into the experiences of Indigenous OTs in Canada. Findings from this study are in line with previously published literature on Indigenous student experiences in health care professions. In reflecting on their experiences as students, Indigenous OT participants noted exclusion, imposed isolation, a lack of support, a devaluing of their merit and skills, and the need to straddle two worlds constantly. They described almost identical experiences as Indigenous clinicians, while also touching on the need to constantly mitigate the 'asks' that come to them and pick their battles within their workplaces. Much of their practice required them to do things differently and draw on their unique strengths as Indigenous OTs. These workplace experiences are underpinned by workplace contexts – notably managerial and colleague support as well as workplace materials that are not always culturally appropriate or culturally safe to use within Indigenous contexts. Both experiences in OT school and in clinical practice are largely due to cultural imperialism, the imposition of Euro-Western knowledge systems being perceived as 'superior'. It is for these reasons that Indigenous OTs have been carving out spaces of belonging for themselves through (often) invisible work. This links directly to the importance of finding allies in non-Indigenous Peoples, given that there are still so

few Indigenous OTs across the country. Unsurprisingly, time is a major barrier that impacts the creation of community outside of formal education and workspaces. Due to this, Indigenous OTs have been calling for the creation of community within OT through the advancement of an Indigenous CoP. The creation of an Indigenous CoP will provide a space that is by us, and for us, and ideally also support the profession to move from Indigenous inclusion to more meaningful ways of utilizing Indigenous knowledges in the OT profession (e.g., moving towards decolonial Indigenization). This dissertation is just the beginning of this important CoP work, and it is hoped that the CoP will begin addressing some of the findings here while also ensuring Indigenous OT students and clinicians feel valued, recognized, and supported in their pursuits within the OT profession.

APPENDIX A – PUBLICATION PERMISSION FORM

May 25th, 2023

Healthy Populations Journal
C/O Healthy Populations
Institute (HPI) Dalhousie
University
1318 Robie Street, Box
15000 Halifax, NS, B3H
4R2

Principal Contact Christie Stilwell Co-Editor in Chief

Dear Christie Stilwell,

I am preparing my PhD in Health thesis for submission to the Faculty of Graduate Studies at Dalhousie University, Halifax, Nova Scotia, Canada. I am seeking your permission to include a portion of the following paper as a chapter in the thesis:

Reid, H., & Pride, T. (2023). Colliding Identities and the Act of Creating Spaces of Belonging in the Occupational Therapy Profession. *The Healthy Populations Journal, 3*(1), 19-29. Doi: 10.15273/hpj.v3i1.11476

Please note that I am only requesting that a portion of this publication appear in my doctoral thesis, not
the full publication. I will be using the portion titled "Tara's story" on pgs. 25-26.

Dalhousie graduate theses are collected and stored online by Dalhousie University and Library and Archives of Canada. I am seeking your permission for the material described above to be stored online in Dalhousie University's institutional repository and in Library and Archives of Canada (LAC)'s Theses Canada Collection.

Full publication details and a copy of this permission letter will be included in the

thesis. Yours sincerely,

Tara Pride
4th year PhD in Health
Candidate Dalhousie
University

Permission is granted for:

a) the inclusion of the material described above in your thesis.

b) for the material described above to be included in the copy of your thesis that is sent to the Library and Archives of Canada inclusion in Theses Canada.

c) For the material described above to be included in the copy of your thesis that is sent to Dalhousie University's institutional repository.

Name: **Christie Stilwell** Title: **Co-Editor in Chief, Healthy Populations Journal**

Date: **May 25, 2023**

APPENDIX B: AGENDA FOR SHARING CIRCLE GATHERING

Indigenous Occupational Therapists (OT) Gathering

October 25th-27th, 2022

PhD Study (Stage 2)

Kjipuktuk, Mi'kma'ki

MEETING AGENDA

October 25th, 2022

- **Dinner (6:00pm) – 2 Doors Down, 1533 Barrington St, Halifax, NS, B3J 1Z6**

October 26th, 2022

- **Breakfast and Opening Prayer with Elder Ann (8:30am-10:00am)**
- Introduction and welcomes, project introduction, discussion of consent, sharing of who people are and getting to know one another (10:00am-12:30pm)
- **Lunch (12:30pm-1:30pm)**
- Preliminary analyses of Stage 1 (storytelling sessions) [recorded for PhD project purposes] (1:30pm-2:30pm)
    - I will present my preliminary themes and the process I've undertaken to develop them
- **Break (2:30pm-2:45pm)**
- Data analysis discussion (2:45pm-4:00pm) [recorded for PhD project purposes]
    - Group discussion on whether the data is representative, any cautions or feedback, things I may have missed, etc.
    - I am using the guiding principle of Two-Eyed Seeing in my work, along with a framework by Gaudry & Lorenz (2018) to challenge the way institutions are doing reconciliation work. I will present how I am using these and why, and I'd like to have a discussion with you all around this.
- **Dinner (6:00pm) – Bluenose II Restaurant, 1824 Hollis St, Halifax, NS, B3J 1W4**

October 27th, 2022

1. **Breakfast and recap from yesterday (9:00am-10:00am)**
2. Introducing an Indigenous Community of Practice (CoP) [recorded for PhD project purposes] (10:00am-11:00am)

- I will present on the development of this CoP and my goals for doing this as part of my PhD work
- Thing I'm interested in knowing about include:
    i. What might participants want out of this? Any cautions? Needed supports?
    ii. Creating a plan moving forward – beginning to formulate a document of recommendations
    iii. Do you see CAOT being involved in this emerging CoP? If so, how? If not, why not?

3. Knowledge dissemination and CAOT abstract submission [recorded for PhD project purposes] (11:00am-12:15pm)
    - I am seeking feedback on ways to disseminate (peer review journals, conferences, reports – who should know this information?) my PhD work that will be meaningful and impactful
    - CAOT abstract submission is due November 1st, 2022. Is there interest is co-writing something from my project?
4. Wrap up (12:15pm-12:30pm)
5. **Lunch and closing prayer with Elder Ann (12:30pm-1:30pm)**

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