Pediatric Occupational Therapists' Journeys Towards Culturally Safer Care Through Participation in a Community of Practice: A Qualitative Study

by

Christine W. Froese

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Rady Faculty of Health Sciences

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Abstract

Rationale

Indigenous communities have identified cultural safety training (ICST) for healthcare providers as one important approach to address racism and health inequities experienced by Indigenous people in Canada. Cultural safety is not achieved through single educational events; it requires ongoing critical reflexivity and engagement by the healthcare provider. Intentional, co-created learning spaces such as Communities of Practice (CoPs) support the ongoing reflexivity and learning needed to strengthen culturally safer practices among occupational therapists.

Objectives

Using constructivist and Indigenist epistemologies, this narrative inquiry explored the: 1) impact of participation in a cultural safety CoP on the attitudes, beliefs and clinical practices of pediatric occupational therapists and 2) value of CoPs as a model for ICST.

Methods

Participants (n=5) engaged in six facilitated CoP sessions. CoP content was guided by the Cultural Safety Framework (CSF) (Horrill et al., 2021), ICST best practices, and participants' expressed learning needs. Data collection included audio-recorded individual, semi-structured interviews before and after the CoP series and group reflections gathered during CoP sessions. Recordings were transcribed verbatim, then coded using directed content analysis based on the Cultural Safety Framework. Participants' journeys were reorganized to reflect a chronological

story of their journeys towards culturally safer care and sent to participants for member-checking. Coded data was analysed to explore themes of participants' journeys.

Findings

Findings are presented in two ways: 1) the re-storied experiences of individual participants, 2) thematically according to the domains of the Cultural Safety Framework: practicing reflexivity, prioritizing relationships and considering context. A fourth theme, becoming unsettled, emerged from the data. Despite varying past experiences, all participants demonstrated changes in attitudes and beliefs, and several expressed early practice changes over the course of the CoP. The CSF offered a helpful structure for the content of the CoP. The CoP structure emphasized relationship-building, a key component in ICST.

Conclusion

CoPs can offer a supportive environment for HCPs to engage in critical reflexivity and anti-racism curriculum. Funders must consider the safety of Indigenous presenters and participants when allocating human and financial resources to ICST programs. Future studies should seek feedback from Indigenous clients to demonstrate clinical impacts of ICST.

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Dedication

This thesis is dedicated to the children and families, living and deceased, who were impacted by residential and day schools. Nothing can change the intergenerational trauma you experienced because of colonization and the harmful attempts to “re-educate” you. I humbly offer this work to contribute to the re-education of settler Canadians.

In the words of the late Honourable Senator Murray Sinclair, “Education got us into this mess. Education will get us out.” (CBC, 2015, as cited in Harrison et al., 2018)

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Introduction

Jordan River Anderson, Brian Sinclair, Joyce Echaquan. Each of these names are tragic examples of how the Canadian health care system struggles to provide safe, effective care to Indigenous people amidst both individual and systemic racism. Jordan River Anderson was a young boy with complex medical needs whose family was from Norway House Cree Nation. Jordan died in hospital at five years of age, never having been to his home community due to jurisdictional disputes between the provincial health system and federal (Indigenous specific) funding programs (Allan & Smylie, 2015; Blackstock, 2016). Brian Sinclair died in a Winnipeg hospital emergency room after waiting 34 hours for assessment and care. Assumptions made related to his race, housing status and sobriety led to a lack of care and ultimately death from sepsis in the emergency department (Allan & Smylie, 2015; Brian Sinclair Working Group, 2017; Logan McCallum & Perry, 2018). Joyce Echaquan died in pain amid racist taunts in a Quebec hospital emergency department, with racism and prejudice playing a role in her death, according to the Coroner's Inquest (Nerestant, 2021). While there are wide health disparities for Indigenous people in Canada (Gracey & King, 2009; Hackett, 2005; Lavoie, 2018; Lavoie et al., 2016), each of these cases illustrates that severe health outcomes are occurring for Indigenous people within our health system because of racism and prejudice, irrespective of health status (Allan & Smylie, 2015; Came & Griffith, 2018). Racism permeates the experiences of Indigenous people in Canada and underpins a multitude of health inequities experienced by Indigenous people (Allan & Smylie, 2015).

Allan and Smylie (2015) argue that racism is in itself a social determinant of health, in addition to other social determinants of health which are perpetuated by racism, such as limited access to stable housing, employment, and education. In their discussion paper on the role of racism in the health of Indigenous people, Allan and Smylie (2015) outline how racist attitudes and beliefs of colonization were used to justify paternalistic laws and policies that limited the mobility and livelihood of Indigenous people. Strategies to "civilize" Indigenous people caused further harm by separating children from their communities, sending them to residential schools where they suffered trauma from poor living conditions and abuses (Allan & Smylie, 2015; *Honouring the Truth*, 2015). Current day stereotypes limit access to housing and employment and place Indigenous children at higher risk of apprehension by social service agencies than non-Indigenous children (Allan & Smylie, 2015; *Honouring the Truth*, 2015). Each of these stressors contribute to inequities in healthcare access and services (Allan & Smylie, 2015).

Occupational therapists (OTs) are healthcare providers that support individuals to engage in the activities (i.e., occupations) they need or want to do (Canadian Association of Occupational Therapists [CAOT], n.d.). Pediatric occupational therapists work with children and their families to identify: barriers to participation in the child's occupations, goals that support participation in occupations and are important to the child and family, and strategies to work towards the identified goals (Case-Smith et al., 2001). A hallmark of pediatric OT is family-centred care. Family-centered care acknowledges the uniqueness of each family, that the family members know their child the best including strengths and challenges, and that the child will do

best in a supportive family environment (Case-Smith et al., 2001; King et al., 1998). Occupational therapists partner with families to determine the best course of action and provide education, tools and resources to achieve the goals established in collaboration between the child, family and occupational therapist (Case-Smith et al., 2001; Law et al., 2003).

Despite the assertion that OT services are based on a family's individual needs and values, OT services remain grounded in Eurocentric norms and values (Grenier, 2020; White & Beagan, 2020). This can be seen in the way independence is centred as a primary goal (Grenier, 2020; White & Beagan, 2020) and how developmental assessments are completed according to Eurocentric norms (Grenier, 2020). There have been increasing calls for OTs to reflect on the colonial history of the profession, the Eurocentric values it is based on, and the impact this has on Indigenous families in particular (Grenier, 2020; White & Beagan, 2020).

The Truth and Reconciliation Commission of Canada (TRCC) Call to Action #23 highlights the need for cultural competence training for healthcare professionals, the need for anti-racism training in medical and nursing schools (2015), and by extension, the obligation of healthcare professionals to provide culturally safe care to Indigenous families. In order for Indigenous peoples' experiences of the health system to improve, providers working in the health system must acknowledge racism and discrimination within the system and make a commitment to change (Allan & Smylie, 2015; Regan, 2010).

Potts and Brown (2015) invite researchers seeking to improve health outcomes of marginalized populations to focus attention on the actions of perpetrators of harm and those that benefit from inequities, rather than on the populations experiencing the inequities. This is

a different approach than has been taken in the past, where research focused on the people experiencing inequities to try to improve outcomes. In order to make health systems safer for Indigenous families and less riddled with racism, we need to focus on care providers working within the system and the changes needed to improve the care they provide (Potts & Brown, 2015).

Cultural safety is a concept that promotes this shift in focus from the perceived deficits of individuals and/or their communities to the strengths of those communities and the systemic barriers and actions of healthcare providers which contribute to health inequities. Cultural safety demands changes in the attitudes and actions of healthcare providers, while acknowledging that the receiver of care is the only one that can determine if care has been culturally safe (Churchill et al., 2017; Papps & Ramsden, 1996; Ramsden, 2002). Briefly, culturally safe care is defined as care in which the healthcare provider is self-reflective and conscious of their own power within the healthcare relationship, and seeks to establish trust and shift power in favour of the individual receiving care (Churchill et al., 2017; Papps & Ramsden, 1996; Ramsden, 2002). This concept will be explored in more detail within the literature review.

Scholars agree that issues of power, historical oppression, and racism must be addressed within healthcare in order to move towards health equity for Indigenous people (Allan & Smylie, 2015; Baker & Giles, 2012; Kelly & Chakanyuka, 2021; Ward et al., 2021). Ward et al. (2021) remind readers that while race is a socially constructed concept, racism has real consequences for the healthcare of Indigenous Peoples' and their experiences of health

inequities. As such, Indigenous cultural safety training (ICST) for healthcare providers and in health professional education has been identified as one method to address racism and oppression within healthcare and thereby address the health inequities experienced by Indigenous people (Allan & Smylie, 2015; Browne, 2017; Churchill et al., 2017; Curtis et al., 2019; *Honouring the Truth*, 2015; Papps & Ramsden, 1996; Ward et al., 2021).

Indigenous communities and researchers, including several in Manitoba, have called on healthcare systems to embrace cultural safety as a means to provide improved healthcare for Indigenous people (Allan & Smylie, 2015; Brian Sinclair Working Group, 2017; Chartier et al., 2020; Fowler-Woods et al., 2022; R. Jones et al., 2019; Kelly & Chakanyuka, 2021; Robinson-Settee et al., 2021; Wylie et al., 2021). Position statements have been published by Indigenous organizations (*Cultural Competency and Safety*, 2008), Indigenous led academic collaborations (Fowler-Woods et al., 2022); institutional collaborations (Brian Sinclair Working Group, 2017); Indigenous research project groups (Robinson-Settee et al., 2021); organizations representing healthcare providers (Bill et al., 2018; CAOT, 2011, 2018; The Indigenous Health Advisory Committee & The Office of Health Policy and Communications, 2013), educators (R. Jones et al., 2019), and trainees (Baker & Giles, 2012) recommending cultural safety training programs for healthcare providers in order to improve quality healthcare and health equity for Indigenous individuals, families and communities.

As a pediatric occupational therapist working in Winnipeg, Manitoba, I have a responsibility to honour and work towards providing quality healthcare for Indigenous families, living up to the spirit of this framework. While I do not currently work in an identified

Indigenous community, Winnipeg is home to the largest metropolitan Indigenous population in Canada (Statistics Canada, 2022) and as such, I work with many Indigenous families within my role. My interest in Truth and Reconciliation, both in my personal and professional life, led to exploration of cultural competence, cultural safety and cultural humility and the role they play in the overall healthcare experiences of Indigenous people. I must also consider how I personally contribute to the experiences of Indigenous families seeking healthcare. This thesis is focused on advancing Indigenous cultural safety in urban pediatric occupational therapy practice.

Positionality

Positionality statements are common in qualitative research as a way to identify the researchers social location, relationship to participant population, and motivations for pursuing the research topic (Creswell, 2014; Ravitch & Carl, 2021). Additionally, Indigenous researchers and communities challenge researchers to identify their background and connection to place when engaging in research related to Indigenous people in order to be explicit about how the researcher is connected to the research topic, the place where the research is occurring, and the community being impacted (Absolon & Willett, 2005; S. Wilson, 2008). Sharing a positionality statement provides the reader with an understanding of my investment in the research, my trustworthiness, and can be used to hold me accountable for my work (Absolon & Willett, 2005). Having had the opportunity to attend a workshop with Wisdom Keeper, Grandmother Mary Wilson and Grandmother Helen Robinson-Settee exploring the Great Questions of Life (Sinclair, 2014), I will use that learning to inform this positionality statement. The questions we considered in the workshop: “Who am I? Where do I come from? What is my purpose? Where am I going?” (M. Wilson & Robinson-Settee, 2021).

My personal journey towards enacting Truth and Reconciliation (*Honouring the Truth*, 2015) led me to explore my role within the healthcare system and its effect on Indigenous families. Do I ignore, allow, facilitate, or excuse racism in our system? Or do I work towards educating myself and improving the care I offer, while supporting, and challenging colleagues and the system to improve as well?

I am a middle aged, White woman of German-Russian-Mennonite background, born to first generation Canadians, living in Treaty 1 territory on Turtle Island (*Treaty 1*, 2022) with my partner, Robert who is of French and English decent. Mennonites have a history of moving in search of religious freedom, settling where farmland was offered to them, while asking few, if any questions about who had occupied that land before we arrived (Encyclopedia Britannica, 2022; Nonkes, 2019). My ancestors did just that when they settled Ukraine in the late 18th century, displacing Kozaks and later when they came to Canada, displacing First Nations and Metis Peoples. My maternal grandparents, Peter and Maggie Klassen, emigrated to Canada in the 1920s as children. They married in their 30s and raised four children in Southwestern Manitoba communities of Manitou and Killarney in Treaty 1 territory. My grandfather was a farmer and my grandmother a seamstress before she married and became a farm wife and mother. My paternal grandparents, Franz and Elizabeth Froese, fled their homes in Ukraine as Russian forces advanced during the second world war, fleeing persecution under Stalin. They were evacuated with retreating German forces, travelling through Poland, settling in Germany, and finally arriving in Canada as refugees on June 2, 1948. They settled in Steinbach, Manitoba, Treaty 1 Territory (*Treaty 1*, 2022) where my opa (grandfather) was a Mennonite minister and worked in a flour mill, building the family home in the evenings and on weekends. My oma (grandmother) raised the family and tended to the farm animals and large vegetable garden to provide for the family. Both sets of grandparents were religious and imparted their Mennonite faith onto my parents, Jacob and Margaret Froese.

My parents married in their early 20s and had two daughters, of which I'm the oldest. Early in their marriage, my parents worked and volunteered in Northern Indigenous communities; first with Christian Investors in Education in the Anishinaabe community of Pauingassi (*Pauingassi First Nation*, n.d.) for five years, then one year with Mennonite Central Committee in the Sayisi Dene community of Tadoule Lake (*About Us*, n.d.). In each community they supported local development of community owned grocery stores. My early childhood years were spent living in these fly-in communities, followed by school years in Winnipeg. Growing up in these small communities, and my religious up bringing in a small Mennonite church in Winnipeg, instilled in me a strong sense of community connections and responsibility. Staying connected with family friends from Pauingassi and Tadoule Lake also provided me with early exposure to the inequities in education and health services. We regularly hosted families that had travelled to Winnipeg to access medical care and boarded teenagers who moved in with us to attend high school as it was not available in their home communities. I had the unacknowledged luxury of living with my own family for high school and university where I trained as an occupational therapist. Within a year of graduating with a bachelor's degree in occupational therapy, I moved to Rankin Inlet, Nunavut to work as an occupational therapist. This experience once again opened my eyes to the inequities in health and social services available to people in remote Inuit communities. As a government employee, I had a good paying job and received subsidies to offset the high cost of living, while many members of the communities lived in severely overcrowded homes due to lack of affordable housing and limited employment opportunities.

I have worked in the area of pediatric OT for the majority of my career, in both hospital and clinic-based outpatient settings. I am now employed in a frontline leadership position within the healthcare system. My role includes family centred occupational therapy assessment and intervention with children under 5 years of age, managing incoming referrals, orientation and training of new staff and mentorship and support for existing staff. With input from staff and discussion with senior leadership, I help to determine educational needs for the department. I have had and still have considerable influence and privilege within my work and personal life.

Having witnessed racist assumptions and actions within the healthcare system over my career, I have not always felt that I had the power or skills to call out such acts. However, as I gained skills, confidence and understanding, I have come to understand my role is to acknowledge racism and disparities when I see them and to work for change from within the system to challenge the system to improve. My goal is to collaborate with likeminded colleagues to work together to create individual and systemic changes within our area(s) of influence.

While reflecting on my role as an occupational therapist working with children and their families in an urban setting, I explored my understanding of Indigenous cultural safety, reflected on my practice with Indigenous families and sought out additional training. Speaking

with therapists that work with the Jordan's Principle Program[1], I noticed the differences in cultural safety training opportunities and the ongoing discussions around culturally safe care. While I fully support the education provided to therapists working directly in Indigenous communities, I also noted that therapists working with Indigenous families in an urban environment do not have the same background in cultural safety training unless we seek it out, and thus, I worry about the potential for unintentional harms for these urban Indigenous families (Browne et al., 2015; Clarke, n.d.; Grenier, 2020). McGuire-Adams (2021) states that there are responsibilities that come with calling oneself a settler which include disrupting the current ways of doing things and acting in a way that seeks improvement and change.

This study is my explicit attempt to engage in critical reflection and learning to become an anti-racist, anti-oppressive occupational therapist and to support colleagues to do the same. By committing to address TRC Call to Action #23, I have committed to pursuing cultural safety in my OT practice and in this research project, addressing the care providers as part of the solution.

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[1] The Jordan's Principle Program is named after Jordan River Anderson. Jordan's Principle states that in cases of funding disputes between federal and provincial agencies related to the healthcare needs of First Nations children, The agency first contacted must fund the request without delay. The government agencies can then work together to determine the final payor. It was adopted unanimously in the House of Commons in 2007, however was not fully implemented until after a Canadian Human Rights Tribunal ruled against the Federal government. (*Jordans Principle | First Nations Caring Society*, n.d.)

Literature Review

In this literature review, I will briefly describe the health impacts of interpersonal and systemic racism that Indigenous Peoples experience when seeking healthcare, followed by the definition and description of cultural safety, key components of cultural safety training and methods of delivery. I will share literature on the effectiveness of such training and examples of best practices in Indigenous cultural safety training (ICST). Finally, I will summarize the literature on the use of communities of practice (CoPs) as tools for professional development in healthcare, and more specifically in the area of anti-racism training.

I completed the literature review in an iterative process, beginning with general reading to narrow the scope of the review, as I developed a clearer understanding of the focus I wanted to take in my thesis work. I read about Truth and Reconciliation within the field of rehabilitation to better understand my role in Truth and Reconciliation and to explore potential research areas related to OT. These initial readings led to topics of racism in healthcare, Indigenous cultural safety, and how these concepts are taught in healthcare settings. Thus, the objective of this literature review became to explore current evidence around Indigenous cultural safety and anti-racism training in rehabilitation.

CINAHL, Medline, Scopus and Google Scholar searches were completed, including the terms “Indigenous”, “cultural* safe*”, “cultural* competen*”, “racis*”, “occupational therap*”, “physical therap*”, “physiotherap*”, “speech therap*”, “speech language patholog*” in various combinations. I found that this therapy-specific search returned very few articles. Therefore, I broadened the search to include healthcare providers (rather than only rehabilitation

professions) and post-secondary training programs for healthcare providers (nursing, medical, and rehabilitation programs). Additional articles were included from reference lists of selected articles, the personal libraries of my advisory committee members, colleagues, course readings, and my own personal library.

I reviewed titles and abstracts of the articles for relevance to the search question. I kept articles if they included: definitions of cultural safety (or related terms), the need for cultural safety in healthcare, description or evaluation of cultural safety training programs or cultural safety initiatives for health professionals or health professional students, evaluation of cultural safety programs or anti-racism program description or evaluations. I did not screen for specific research methods such as systematic reviews or randomized controlled trials, rather sought a broad understanding of the concepts. I intentionally sought to include studies done by Indigenous researchers or initiated by engagement with Indigenous communities.

Following article selection, I read the full articles, grouping them into themes discussed in this chapter including: health inequities and racism, definition of cultural safety in healthcare, core concepts in cultural safety curricula, effectiveness of cultural safety training and best practices in cultural safety training in healthcare. While reading the articles Indigenous experiences and understandings of racism and cultural safety were privileged.

Health Inequities and Racism

Inequities in Indigenous health outcomes, such as higher rates of morbidity, mortality, infant death rates and shortened life expectancy, have been extensively documented and often linked to social determinants of health or individual lifestyle choices (Gracey & King, 2009). Two

local population health studies comparing First Nations' health status with all other Manitobans emphasize that there exists health inequities including both poorer health status, and poorer access to health services in Manitoba (Chartier et al., 2020; Katz et al., 2019). In fact, Katz et al. (2019) found that health gaps between Indigenous and non-Indigenous Manitobans have increased since 2002.

Several authors have explored the underlying causes of the health gaps between Indigenous and non-Indigenous people and are increasingly identifying colonialism, racism, and trauma as direct contributors to these inequities (Allan & Smylie, 2015; Paradies, 2016). Racism has been cited as a specific contributor to inequitable care for Indigenous children (Blackstock, 2016) and preventable deaths of Indigenous adults in the hospital system (Brian Sinclair Working Group, 2017; Nerestant, 2021). The experience of racism, both individual and systemic, is described as a unique social determinant of health and a barrier to care for Indigenous people (Allan & Smylie, 2015; Czyzewski, 2011). Taken together these findings highlight the need to directly address racism in healthcare practices to support improved health outcomes for Indigenous individuals, families and communities.

The profession of occupational therapy prides itself on its person-centred approach to care (Townsend & Staton, 2002). However, it too perpetuates racism and colonialism by privileging Western (usually White) norms and values (Beagan et al., 2022; Grenier, 2020; Hunter & Pride, 2021; White & Beagan, 2020). Examples of how white supremacy is harmfully enacted into practice include: centering independence as the ultimate goal, maintaining hierarchy between individual receiving care and OT as expert, using developmental and

standardized assessments based on Western concepts which do not reflect Indigenous knowledge and values, separating occupations (self-care, productivity and leisure) from the environment they occur in, and focusing on intervention at the level of the person rather than an approach integrating the community and place (Grenier, 2020; Hunter & Pride, 2021; White & Beagan, 2020). As such, occupational therapists have contributed to harms done to Indigenous people. Occupational therapists must reflect on and change our practices, both as individuals and as a broader profession, to ensure we do not cause harm through our practices, but rather support health and healing.

Cultural Safety Training

Calls to improve Indigenous peoples' experiences of the healthcare system through healthcare provider training in cultural competence or cultural safety have been occurring for decades (Gerlach, 2012; Papps & Ramsden, 1996; Ramsden, 2002; Tenasco, 2014). The concept of cultural safety originated in response to health inequities experienced by Māori people in Aotearoa/New Zealand where Māori people were demanding improvements to the healthcare they were receiving (Papps & Ramsden, 1996). Māori nurses and midwives, including Irihapeti Ramsden, advocated for the need for nursing practices to be decolonized, building trust between nurses and the individuals they care for, shifting power from nurses to the receiver of care, and ultimately improving communication and access to care for Māori people (Papps & Ramsden, 1996; Ramsden, 2002). Advocacy for, and adoption of, cultural safety as a practice model to support health equity for Indigenous peoples has since spread beyond Aotearoa/New Zealand to regions with similar colonial histories including Australia, Canada, and South

America, where Indigenous populations also experience health inequities when compared to the settler population (Brooks-Cleator et al., 2018; Mills et al., 2022; Pimentel et al., 2022; Ramsden, 2002).

The calls for cultural safety training were renewed in Canada following the release of the Truth and Reconciliation Commission of Canada's final report in 2015 (Churchill et al., 2017; *Honouring the Truth*, 2015) and more recently with the deaths of Brian Sinclair (Brian Sinclair Working Group, 2017) and Joyce Echaquan (Lafond et al., 2021; Nerestant, 2021) demonstrating the ongoing issues of racism and healthcare access in Canada.

Concepts Associated With, But Distinct from Cultural Safety

Next, I will describe concepts that are similar to, but distinct from, cultural safety. I will then describe cultural safety as a distinct concept, the key components of Indigenous cultural safety training (ICST), methods for delivery and effectiveness of ICST. Finally, I will review best practices in ICST, occupational therapy specific ICST, and organizational responsibilities in relation to ICST.

There are several concepts that are similar to, but distinct from the concept of cultural safety. These include cultural awareness, cultural sensitivity, cultural competence, and cultural humility. Understanding the distinctions between them can help to highlight the key features, challenges, and strengths of each. Curtis et al. (2019) reviewed 59 articles defining cultural competence, cultural safety and other related terms while working to update cultural competency curriculum in Aotearoa/New Zealand. Curtis et al. (2019) concluded that cultural safety remains the most appropriate concept when working to achieve health equity for

Indigenous communities due to its focus on power inequities and critical reflexivity on the part of health care providers. This section provides a brief overview of each of the most common terms related to cultural safety in order to describe their distinctions from each other and explain my focus on cultural safety. Ward et al. (2016) also summarize the related terms concisely and are oft quoted to describe the differences between the terms which follow.

Cultural Awareness. Cultural awareness highlights the differences between a learner's culture and the "other", which may include teachings about language, customs and values of specific cultures (Curtis et al., 2019; Ward et al., 2016). The focus of cultural awareness training remains on the difference of the "other" and does not include reflection on one's own cultural values, attitudes and beliefs (Curtis et al., 2019; Pimentel et al., 2022). Self-reflection and critical reflexivity are not demanded of the learner in cultural awareness training (Curtis et al., 2019).

Cultural Sensitivity. Cultural sensitivity builds on the awareness of differences between cultures, the validity of those differences, and the need for respect of those differences (Curtis et al., 2019)**.** Ward defines cultural sensitivity as "an attitude that recognizes the differences between cultures and that these differences are important to acknowledge in health care"(2016, p. 2).

Cultural Competence. Ward defines this as "an approach that focuses on practitioners' attaining skills, knowledge, and attitudes to work in more effective and respectful ways with Indigenous patients and people of different cultures" (2016, p. 2). A danger in focusing on cultural competence is the emphasis on gathering facts about cultures or attempting to become

an “expert” in another culture while continuing to “other” the individual receiving care, focusing on difference and prioritizing a Western, White perspective (Curtis et al., 2019; Gerlach, 2012; Grenier, 2020). A continued focus on learning skills to work with a person from a different culture maintains power imbalances in favour of the healthcare provider and maintaining the social structures rather than changing healthcare providers underlying attitudes (De Leeuw et al., 2021; Gerlach, 2012).

Cultural Humility. “An approach to health care based on humble acknowledgement of oneself as a learner when it comes to understanding a person’s experience. A life-long process of learning and being self-reflexive” (Ward et al., 2016, p. 2). Cultural humility reorients the focus from the culture of the individual receiving care to the provider’s own behaviour and the provider’s understanding of the impacts of their biases and the power structures within society (Johnson & Sutherland, 2022). When healthcare providers engage in the self-reflection required to demonstrate cultural humility, they will then begin providing culturally safer care (Johnson & Sutherland, 2022).

Definition of Cultural Safety

Cultural safety was initially described by Māori nurses and midwives in New Zealand (Ramsden, 2002). It grew out of the acknowledgement that the attitudes and beliefs held by healthcare providers towards Indigenous patients was affecting their health outcomes (Papps & Ramsden, 1996). Culture is broadly defined to include, but not limited to “age, gender, sexual orientation, socioeconomic status and class, ethnic origin, religious or spiritual beliefs, or disability” (Jungerson, 2002 as cited in Gerlach, 2012). Cultural safety “is about the analysis of

power and not the customs and habits of anybody" (Ramsden, 2002, p. 181). Cultural safety acknowledges social historical contexts in the provision of healthcare services and ensures equitable access to quality healthcare in a way that addresses power imbalances, establishes trust, and works to promote health equity (Bourassa et al., 2020; Gerlach, 2012; Ramsden, 2002; Ward et al., 2016). Whether care is culturally safe or not can only be determined by the person receiving care (Browne et al., 2009; Gerlach, 2012; Johnson & Sutherland, 2022).

Ward et al. (2016) provide this oft cited definition of cultural safety that sums up these ideas:

> An approach that considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences. Practitioners are self-reflective/self-aware with regards to their position of power and the impact of this role in relation to patients. 'Safety' is defined by those who receive the service, not those who provide it. (2016, p. 2)

Culturally safe practice has been described by some as a continuum (Gerlach, 2012; Tenasco, 2014). At one end, clinical care is unsafe or destructive and perpetuates stereotypes, while at the opposite end culturally safe care builds respectful relationships and returns decision making power to the receiver of care (Churchill et al., 2017; Pimentel et al., 2022; Public Health Agency of Canada, 2019; Tenasco, 2014). Concepts such as cultural awareness, cultural sensitivity, cultural competence, and cultural humility are seen by some as steps along the path to culturally safe care (Churchill et al., 2017; Lavoie et al., 2022; Tenasco, 2014). It is important to note that the stepwise path is debated. For example, in relation to cultural

awareness, one practitioner cannot be aware of all cultures, but can provide quality healthcare services in a culturally safe way through practices of self-reflection, humility, and building a trusting, collaborative relationship with the individual receiving care (Bourassa et al., 2020).

Cultural safety (rather than awareness or competence) was chosen as the central concept for this project because it has been developed and continues to be endorsed by Indigenous communities (Browne et al., 2021; Fowler-Woods et al., 2022; Guerra & Kurtz, 2017; Papps & Ramsden, 1996; Ramsden, 2002; Robinson-Settee et al., 2021; Ward et al., 2016). Cultural safety demands the most of healthcare practitioners, in terms of critical reflection, on their own beliefs and actions, addressing power dynamics and establishing trusting relationships, while leaving the power to define success with the individual experiencing the care (Papps & Ramsden, 1996; Ward et al., 2016). Given the continued negative experiences of Indigenous people seeking healthcare (Brian Sinclair Working Group, 2017; Goodman et al., 2017; Nerestant, 2021), it is evident that we, as healthcare providers and the healthcare system, have not yet achieved the goal of culturally safe care.

For this project I am considering cultural safety as an overarching concept which centres the family's perspective of the care they receive, relationship with the care provider, and power sharing as described by Papps and Ramsden (1996). It is not necessary for the healthcare provider to be knowledgeable about the specific culture of the individual receiving care (as it is with cultural awareness) but rather to reflect on their own positionality, power, and the impact of colonization and the healthcare provider's impact on the experience of the individual and family receiving care. In becoming a culturally safer healthcare provider, the provider will need

to demonstrate cultural sensitivity and humility and may gain some awareness of cultures other than their own; however, these concepts are seen as interwoven in the process of becoming a culturally safer practitioner, not unique skills to be mastered.

Core Components of Indigenous Cultural Safety Training

Core components of Indigenous cultural safety training (ICST) curricula are derived from the definition of cultural safety and ongoing research into Indigenous experiences of culturally safe care; they include: reflexivity, relationship focused approach, power sharing, anti-racism, contextual awareness and, more recently, violence- and trauma-informed care (Bourassa et al., 2020; Browne, 2017; Goodman et al., 2017; Papps & Ramsden, 1996; Ward et al., 2021). As discussed in the previous section, the definition of cultural safety encompasses the need for healthcare providers to: reflect on their own culture and the influence it has on client interactions, acknowledge and address their own biases and the power imbalances within healthcare interactions, and the need for trust to be established (Bourassa et al., 2020; Papps & Ramsden, 1996). Additionally, a commitment to anti-racism and health equity approaches have been emphasized in recent years as an important component of culturally safe care (Bourassa et al., 2020; Browne, 2017; Diffey & Mignone, 2017; Horrill et al., 2021; Kelly & Chakanyuka, 2021).

There is a gap in the literature related to content of cultural safety training curriculum. Definitions of cultural safety (Bourassa et al., 2020; Curtis et al., 2019; Ramsden, 2002; Ward et al., 2016), descriptions of culturally safe care (Chakanyuka et al., 2022; Goodman et al., 2017), and individual or community outcomes resulting from culturally safe care have been described

(Churchill et al., 2020; Truong et al., 2014). While there is consensus among researchers on the core components that should be included in ICST (Browne et al., 2021; Chakanyuka et al., 2022; *Cultural Competency and Safety*, 2008; Curtis et al., 2019; R. Jones et al., 2019; Public Health Agency of Canada, 2019; Ward et al., 2021), descriptions of ICST curriculum content is limited to brief overviews (Browne et al., 2021; Ward et al., 2021) or detailed descriptions of individual components only, such as reflexivity or anti-racism curricula (Dawson et al., 2022; Diffey & Mignone, 2017; Sjorberg & McDermott, 2016).

Chakanyuka et al. (2022) completed a scoping review of reviews to examine the ways Indigenous cultural safety (ICS) is defined, and key elements of culturally safe care and approaches used to facilitate ICS in practice settings. The authors, two thirds of whom are Indigenous, used Indigenous research approaches within the scoping review process, consulting with Indigenous researchers, healthcare providers, and community leaders while developing the research question and during analysis (Chakanyuka et al., 2022). With respect to ICST curriculum and systemic approaches to ICS, the authors report that in the 17 review articles included in the scoping review, descriptions of the curricula used were limited (Chakanyuka et al., 2022). When details of the curricula or interventions were available, topic areas included: healthcare provider reflexivity including critical reflexivity about their own biases, assumptions and actions, power dynamics between healthcare provider and individual receiving care, interpersonal and systemic racism, and the historical context of colonization and its impact on Indigenous people (Chakanyuka et al., 2022).

Given the consistency of the themes found by Chakanyuka et al. (2022) in cultural safety initiatives and training content with the well-established definitions of cultural safety (Bourassa et al., 2020; Browne et al., 2021; Ramsden, 2002; Ward et al., 2016), I considered reflexivity, focus on relationship, power sharing, anti-racism, contextual awareness, and trauma- and violence-informed care as core components of Indigenous cultural safety training for the purpose of this project. In the following sections, each core component is described in more detail gained through review of descriptions within individual studies and reports.

Reflexivity. Reflexivity is a key concept that sets cultural safety apart from cultural awareness and cultural competence (Curtis et al., 2019; Gerlach, 2012; Ward et al., 2016) and is described as an essential, baseline skill for culturally safe care provision (Bourassa et al., 2020; Dawson et al., 2022; Tenasco, 2014; Truong et al., 2014; Wray & Mortenson, 2011). Dawson et al. (2022) reviewed 46 articles describing Indigenous cultural safety curriculum from Australia, Aotearoa/New Zealand, Canada and the United States and found greater than 85 percent of programs emphasized development or engagement in reflexivity as a core component of the education. There is consensus among scholars on ICS that healthcare providers' reflexivity regarding their own positionality, biases, stereotypes, power, privilege and professional values is required in order to engage in the other core components of ICST such as building trusting relationships, power sharing, and anti-racism (Bourassa et al., 2020; Chakanyuka et al., 2022; Churchill et al., 2017; Curtis et al., 2019; Dawson et al., 2022; Gerlach, 2012; Papps & Ramsden, 1996; White & Beagan, 2020; Yaphe et al., 2019).

Relationship Focused. While developing a conceptual framework to measure Indigenous cultural safety in healthcare, Johnson and Sutherland (2022) explored core concepts of cultural safety and initiatives used to promote culturally safer care for individuals and communities. Johnson and Sutherland (2022) state that relationality is central to Indigenous ways of knowing and being and "the relationship between patient and provider… determines the extent to which the patient deems their care as culturally safe" (Johnson & Sutherland, 2022, p. 6). In other words, it is in the relationship between healthcare provider and the individual or family receiving care that cultural safety will be seen. Investing time to get to know an individual and their life circumstances, rather than engaging with them based on stereotypes or assumptions, is critical to establishing the trusting, collaborative relationships on which cultural safety is built (Bourassa et al., 2020; Byrne et al., 2020; Health Council of Canada, 2012; Horrill et al., 2021; Papps & Ramsden, 1996). Focusing on the human relationship generates understanding of values of the receiver of care, accountability of the healthcare provider, and reciprocal learning opportunities between receiver of care and healthcare provider (Bourassa et al., 2020; Health Council of Canada, 2012)

Power Sharing. In order to practice in a culturally safe way, healthcare providers must be attentive to issues of power (Curtis et al., 2019; Horrill et al., 2021; Ramsden, 2002; Ward et al., 2021). Acknowledging the power inequities between individuals receiving care and HCPs and intentionally engaging in strategies to balance and share power is necessary to build the trusting relationships required for culturally safe care (Curtis et al., 2019; Horrill et al., 2021; Papps & Ramsden, 1996; Ramsden, 2002).

Recognition of the HCP's own power and privilege is needed before strategies to share power can be implemented (Browne et al., 2009; Churchill et al., 2020; Diffey & Mignone, 2017; Horrill et al., 2021; Tenasco, 2014). Approaches to support knowledge exchange between the individual receiving care and HCP, collaboration in care planning and facilitating individuals control over decision making processes in their own healthcare enable this shift of power (Gerlach, 2012; Horrill et al., 2021; Papps & Ramsden, 1996).

Anti-Racism. An understanding of the interpersonal and institutional forms of racism in healthcare and the underlying biases, stereotypes, and structures that support them is required for individual and system level cultural safety interventions (Allan & Smylie, 2015; Browne, 2017; Browne et al., 2021; Churchill et al., 2017; Diffey & Lavallee, 2014; Wylie et al., 2021). While seeking to define best practices in cultural safety, Churchill et al. (2017) described seven wise practices found in peer reviewed and grey literature; the third wise practice highlights "decolonizing , anti-racist pedagogy" (p.9) as essential in ICST. Churchill et al. report that addressing racism, along with issues of power, and privilege, is "one of the strongest findings that emerged" (2017, p. 9) in their review of the literature. In Dawson et. al.'s (2022) examination of reflexivity in ICST, they found that all educational programs reviewed included content on the harms of racism and colonisation in the curriculum.

Kelly and Chakanyuka (2021) argue while specific language demanding anti-racist actions is not included in the early definitions of cultural safety, it is implied within the definition and is essential in order to achieve culturally safe practice. Supporting this assertion

is the finding that racism and its impact on Indigenous people is a central theme of ICST described in the scoping review completed by Chakanyuka et al. (2022).

Taken together, the literature exploring ICS initiatives and training curricula (Chakanyuka et al., 2022; Churchill et al., 2017; Dawson et al., 2022; Kelly & Chakanyuka, 2021; Wylie et al., 2021) and the established definitions of cultural safety (Bourassa et al., 2020; Browne et al., 2021; Diffey & Lavallee, 2014; Truong et al., 2014; Ward et al., 2021) indicate that the discussion of racism, its impacts on the healthcare of Indigenous people, and strategies to interrupt racism are essential in ICST.

Contextual Awareness. The Canadian education system has long presented a one sided view of the country's history, leaving many Canadians unaware of the impacts of colonization, residential schools and intergenerational trauma experienced by Indigenous people in this nation (Sinclair, 2014). Current contexts faced by Indigenous people including racism, inequitable government policies and funding schemes, limited healthcare access due to geographical and infrastructure limitations, and income inequality must also be considered when providing culturally safe care (Allan & Smylie, 2015; Bourassa et al., 2020; Churchill et al., 2017; Horrill et al., 2021). Healthcare providers must have an understanding of both historical and current contextual factors in order to challenge systemic barriers contributing to healthcare inequities and collaborate with the receiver of care about addressing their healthcare priorities (Horrill et al., 2021).

Trauma- and Violence-Informed Care. Several scholars advocate for including trauma- and violence-informed care (TVIC) along with cultural safety in order to consider a broader

health equity approach to healthcare (Browne et al., 2015; Gerlach et al., 2021; Horrill et al., 2021; Public Health Agency of Canada, 2019). Trauma- and violence-informed care centres the individual's physical and psychological safety in the healthcare experiences, taking into account their current and past context and experiences in order to create a trusting relationship in which the individual receiving care is empowered to manage healthcare decisions and minimizing risk of re-traumatization (Horrill et al., 2021). Horrill et al. (2021) argue that TVIC and cultural safety share attention to relationships, power inequities and address structural barriers. Additionally, TVIC explicitly addresses physical safety concerns and the impact of past trauma and violence and strengths-based approaches to care including individual choice making about their own care (Horrill et al., 2021; Public Health Agency of Canada, 2019).

Delivery Methods for Cultural Safety Training

Methods for delivering ICST vary widely from curated reading lists (*Cultural Competency*, 2016) and self-directed learning modules (*Indigenous Allyship Toolkit*, 2020) to established educational programs delivered over varied lengths of time (Browne et al., 2021; MacLean et al., 2023; Rand et al., 2019; Yaphe et al., 2019) and multi-tiered cultural safety interventions with integrated education components (Browne et al., 2015, 2018). The variability of the delivery methods makes comparing methods to determine which are most effective challenging (Curtis et al., 2019; MacLean et al., 2023; Truong et al., 2014). I will describe one scoping review that summarizes delivery methods for ICST (MacLean et al., 2023). I will then discuss calls for continual engagement with ICST rather than participation in ICST as single learning event

(Bourassa et al., 2020; Johnson & Sutherland, 2022; Robinson-Settee et al., 2021; Wylie et al., 2021).

A scoping review aiming to describe the development, implementation, and evaluation of ICS training and intervention programs for health, social work, and education professionals was completed by MacLean et al. in 2023 and identified 134 articles describing programs in New Zealand, Australia, United States, and Canada between 1996-2020. MacLean et al. (2023) found that program duration ranged from single day to multi-semester programs, with most completed within 1-5 sessions. Single event training was described in 10/69 articles and longer series lasting one to five weeks occurred in 7/69 reports (MacLean et al., 2023). Lecture style training was the most prevalent method of delivery, followed by workshops and discussion groups, and then community engagement programs (MacLean et al., 2023). There was a somewhat even distribution between these styles with lectures taking place in about one third of the ICST programs, and the other methods occurring between one quarter (workshops, discussion groups) and one fifth of the programs (community engagement). Other teaching methods including learning modules, case-based studies, assigned readings and group activities were less frequently reported (MacLean et al., 2023). While MacLean et al. (2023) also discussed the effectiveness of ICST (discussed in the following section in this review), they did not link the method nor duration of programs to program effectiveness, making it impossible to determine which approach may be better suited to effective ICST outcomes.

When I reviewed literature describing ICST programs specific to healthcare students and professionals, I found similar results to MacLean et al. (2023), i.e., approaches to providing ICST

in healthcare are varied in their methods and duration. They include brief workshop style events (Herzog et al., 2021; MacCormick, 2021), community immersion experiences (De Leeuw et al., 2021), and facilitated courses running over weeks to months as standalone courses or integrated into university curriculum or health equity program delivery (Browne et al., 2018, 2021; Byrne et al., 2020; Mills et al., 2022; Robinson-Settee et al., 2021). A strategy described in the grey literature that was not found by MacLean et al. is the use of self-directed learning packages as supplements to other courses or as a stand-alone options offered by healthcare related organizations/authorities (Ariano et al., 2021a; *Cultural Competency*, 2016; *Indigenous Allyship Toolkit*, 2020).

Continual learning and engagement. The literature has shown that Indigenous cultural safety practices require ongoing engagement in critical self-reflection (Curtis et al., 2019; Dawson et al., 2022; Truong et al., 2014) and focus on the relationships between clients and healthcare providers (Bourassa et al., 2020; Byrne et al., 2020; Horrill et al., 2021; Johnson & Sutherland, 2022; Papps & Ramsden, 1996). As such, it has been argued by many scholars that time limited training is not sufficient, rather healthcare providers should be supported by the organizations within which they work to engage in cultural safety learning and practice in an ongoing way (Bourassa et al., 2020; Churchill et al., 2017; Kelly & Chakanyuka, 2021; Robinson-Settee et al., 2021; Wylie et al., 2021). In a qualitative study exploring the experiences of both Indigenous and non-Indigenous healthcare providers with cultural safety training in order to identify strengths, challenges and guide future ICST to improve effectiveness of the training, Wylie et al. (2021) found the importance of continual engagement with critical self-reflection

and learning in order to work in a culturally safe way was emphasized by participants. Engagement with ICST "needs to be seen as a lifelong journey, not a one-off check box" (Wylie et al., 2021, p. 327). Several ICST models are beginning to incorporate follow-up or multi-stage educational opportunities for healthcare providers (Browne et al., 2021; MacLean et al., 2023; Robinson-Settee et al., 2021), while others are incorporating cultural safety as a central component of organizational transformation towards equity oriented care (Browne et al., 2015, 2018). No matter the approach to ICST, ongoing engagement, reflection, and improvement are recommended to move healthcare practices to culturally safer care and improved health equity for Indigenous people (Browne et al., 2015, 2018, 2021; MacLean et al., 2023; Robinson-Settee et al., 2021; Wylie et al., 2021).

Evidence for Effectiveness of Cultural Safety Training

ICST aims to improve Indigenous peoples' healthcare experiences and ultimately, improve their health outcomes (Churchill et al., 2017; Papps & Ramsden, 1996; Public Health Agency of Canada, 2019; Ramsden, 2002), however in order to determine if ICST is meeting this goal, programs need to be evaluated. In this section I will present findings of a concept analysis which describes anticipated outcomes of ICST (Henderson et al., 2018), followed by a scoping review of reviews (Truong et al., 2014) and a systematic scoping review (Jongen et al., 2018) which build on each other. These reviews state that evaluation of ICST tends to focus on HCP self-report rather than the experiences of individuals receiving the care (Henderson et al., 2018; Jongen et al., 2018; Truong et al., 2014); however the review of reviews completed by Truong et al. (2014) does include some evidence of improved outcomes reported by individuals

receiving care as a result of ICS interventions. I will then describe evidence for effectiveness of two Canadian ICST programs which were not included in the reviews: San'yas ICST and EQUIP (Browne et al., 2018, 2021).

Henderson et al. (2018) completed a concept analysis of cultural competence, including related terms such as cultural safety, which identified antecedents, attributes and consequences of cultural competency in community healthcare practice. In the analysis, Henderson et al. (2018) identified the following consequences of culturally safe care: individuals receiving care perceive high quality of care, they report satisfaction with healthcare, they show improved adherence to treatment plans, and communication between healthcare providers and individuals receiving care is effective, each of which lead to improved health outcomes for individuals receiving care. Despite these theorized outcomes of culturally safe care for individual receiving care, measurement of effectiveness of cultural safety training frequently focuses on healthcare providers' knowledge, attitudes, beliefs, and reported behaviours (Browne et al., 2018, 2021; Jongen et al., 2018; Truong et al., 2014) rather than health outcomes of Indigenous people.

In 2014, Truong et al. published a systematic review of reviews which included 19 reviews published between 2000-2012 reporting on effectiveness of cultural competency interventions within healthcare settings. Interventions described in the reviews included healthcare provider education/training, adapting patient care programs to meet the cultural needs of the population served, patient access supports (interpreter and navigator services), and organizational approaches. Outcomes described in the studies reviewed included:

healthcare provider knowledge, attitudes and skills, client satisfaction, client follow-through with recommendations, physiological health outcomes and access to care. While Truong et al. (2014) found there was good quality evidence that cultural safety interventions had a positive impact on healthcare provider knowledge, attitudes and skills, the heterogeneity of intervention approaches meant that effectiveness of any one particular approach could not be determined. Additionally, self-report was frequently used for healthcare provider outcomes, introducing validity concerns (Truong et al., 2014). Evidence for patient specific outcomes often focused on culturally adapted, disease specific interventions (e.g. diabetes education or cancer screening). There was improvement noted in patient specific outcomes in 7/9 of the reviews that examined patient specific outcomes and two reviews were inconclusive on patient related improvements (Truong et al., 2014).

Jongen et al. (2018) completed a systematic scoping review examining cultural competence interventions for healthcare workers. They completed blinded reviews of 16 articles, finding the quality in almost two thirds of the studies to be weak (Jongen et al., 2018). Eleven of the articles reviewed described cultural competency training while the rest used professional development strategies including mentorship and supervision of practice to influence cultural safety practices (Jongen et al., 2018). Of the articles describing cultural competency training, outcomes included improved healthcare provider knowledge, attitudes, beliefs, skills and confidence (Jongen et al., 2018). Self-report was again highlighted as the primary measurement tool for healthcare provider outcomes (Jongen et al., 2018).

Individual studies examining cultural safety training since the completion of the aforementioned reviews continue to focus primarily on healthcare provider or student outcomes using self-report measures (Browne et al., 2018, 2021; Herzog et al., 2021; Mills et al., 2022). Evaluation outcomes of the San'yas Indigenous cultural safety training program, described further in the ICST exemplars section, are briefly described by Browne et al. (2021) to include improved: knowledge and awareness about colonization and its effects, ability to identify strategies to address racism and to use them in the workplace, and engagement in critical refection regarding systemic and interpersonal racism. These outcomes are measured using de-identified data from the online program itself, pre- and post-tests and survey results (Browne et al., 2021), however details of the evaluation methodology are not included in the article, preventing evaluation of the rigour of the evaluation techniques.

EQUIP is an organization level intervention which aims to facilitate the provision of equity oriented healthcare to Indigenous and marginalized populations through cultural safety, trauma informed care and harm reduction education, and interventions tailored to the organization (Browne et al., 2015, 2018). While an evaluation of this intervention was completed for the entire program, specific findings point to the effectiveness of the cultural safety training component (Browne et al., 2018). Results of staff surveys, in depth interviews, and clinical observations by the research team demonstrated increased confidence and skills of participants (staff members) to address racism on an interpersonal level, but also to acknowledge and problem solve around addressing systemic racism (Browne et al., 2018). On the other hand, Browne et al. (2018) noted some participants expressed discomfort with the

cultural safety education due to the focus on historical trauma and colonization; this discomfort or resistance has been noted within other cultural safety and anti-racism programs as well (Beavis et al., 2015; Browne et al., 2009; Ward et al., 2021). While the evaluation was completed for the EQUIP intervention as a whole, both quantitative and qualitative findings point to improvement specifically in cultural safety knowledge, confidence, and skills as a result of cultural safety training provided (Browne et al., 2018).

Overall, Indigenous cultural safety training is theorized to support improved health outcomes for people receiving care (Henderson et al., 2018), however the majority of the measured outcomes are focused on healthcare providers' self-report (Browne et al., 2018, 2021; Jongen et al., 2018; Truong et al., 2014). There is good evidence to support improvement in self-reported critical reflexivity, knowledge and awareness about cultural safety, and improved skills required in order to provide culturally safer care (Browne et al., 2018, 2021; Jongen et al., 2018; Truong et al., 2014), however, studies regarding improved health outcomes for people receiving care as a result of ICST for healthcare providers are less conclusive and require further evaluation over longer periods of time (Jongen et al., 2018). Given that the stated purpose of ICST is to address the health inequities experiences by Indigenous populations (Ramsden, 2002), future effectiveness studies should measure improvements in health outcomes for Indigenous populations (or lack thereof) in order to determine the ultimate effectiveness of ICST with healthcare providers. Finally, in order to be effective, ICST programs must anticipate and plan to address discomfort and resistance of participants when

discussing the contributions of racism, colonization, and historical trauma to health inequities of Indigenous people (Beavis et al., 2015; Browne et al., 2009, 2018; Ward et al., 2021).

Best Practices in Indigenous Cultural Safety Training (ICST)

Best practices for ICST should reflect the core components identified in ICST, incorporate the evidence for effectiveness of ICST and be delivered in a way that supports learning. In 2017, Churchill et al. initiated a scoping review of best practices in Indigenous Cultural Safety Training (ICST). Finding only seven articles published in the preceding five years with limited quality, they broadened their search to explore theoretical and practical applications for the development on ICST curriculum and programs. The review resulted in the development of "wise practices for developing and implementing Indigenous-specific cultural safety training" (Churchill et al., 2017, p. 8) to guide curriculum and training development. The wise practices are:

> Wise Practice #1: Cultural safety training programs need to be evaluated.
>
> Wise Practice #2: Cultural safety training programs need detailed program descriptions in order to be consistently and reliably implemented and evaluated.
>
> Wise Practice #3: Cultural safety training programs would benefit from curriculum that focuses on power, privilege, and equity; is grounded in decolonizing, anti-racist pedagogy; and is based on principles from transformative education theory.
>
> Wise Practice #4: Cultural safety training programs must be led by trained facilitators.

> Wise Practice #5: Cultural safety training programs must be offered in effective learning spaces that both challenge resistance from non-Indigenous peoples, and support non-Indigenous peoples to learn from their discomfort.
>
> Wise Practice #6: Cultural safety training programs need to prioritize support for Indigenous learners.
>
> Wise Practice #7: Cultural safety training programs cannot work in isolation; system-level support is required for accountability and organizational transformation. (Churchill et al., 2017, p. 15)

Despite the fact that these wise practices were described almost six years ago (Churchill et al., 2017) and are often cited in Canadian publications describing ICST and health equity approaches (Browne et al., 2021; Herzog et al., 2021; *Indigenous Allyship Toolkit*, 2020; Nixon, 2019; Ward et al., 2021; Whitinui et al., 2021), detailed descriptions of curriculum content (Chakanyuka et al., 2022) and robust evaluation of effectiveness of these programs (Jongen et al., 2018; MacLean et al., 2023) remain limited or poorly reported.

ICST Exemplars. Two examples of Indigenous cultural safety training follow, each meets Churchill et al.'s (2017) wise practices criteria. The San'yas Indigenous Cultural Safety Training Program was identified by Churchill et al. (2017) as a leading practice in ICST for healthcare providers, while Equipping Primary Health Care for Equity (EQUIP) is an extension of ICS including organizational strategies to support harm reduction approaches and tailoring services to support health equity for marginalized populations in the training as well (Browne et al., 2015). I have included EQUIP as an exemplar based on the stated commitment to health equity

and integration of ICST into the training, organizational policies, procedures and programing and inclusion of ICS components in the evaluation completed (Browne et al., 2015, 2018).

San'yas Indigenous Cultural Safety Training Program. Churchill et al. (2017) identified the San'yas Indigenous Cultural Safety Training Program as a well-established ICST program. Developed in consultation with Indigenous communities in British Columbia, it has been operating since 2010 and has been adapted for use in Ontario and Manitoba in 2013 and 2016 respectively (Browne et al., 2021). The program provides an eight week moderated, asynchronous learning platform with curriculum based on "decolonizing, anti-racist, transformative and adult education theories" (*About — San'yas Indigenous Cultural Safety Online Training*, n.d.). Additional workshops are available for further exploration of cultural safety in practice as well as for other government workers in areas of child welfare and justice (*Core Training — San'yas Indigenous Cultural Safety Online Training*, n.d.).

Evaluations of the San'yas program and its variations across the country have been completed through participant surveys, pre-and post- program surveys and thematic analysis of discussion board content (Browne et al., 2021). The specific evaluation tools used are not shared in the report however, Browne et al. (2021) summarized these results saying the program supported improved knowledge and skills around racism and discrimination with 93% of participants indicating they will use their new knowledge within their daily work and would recommend the training to others. Additionally, qualitative findings show the program supports critical reflexivity among participants and the development of skills to confront racism within the workplace (Browne et al., 2021)

The San'yas program is now being included as one component of the cultural safety educational programs provided by healthcare and health research organizations to support healthcare providers in their journeys to become culturally safer practitioners (*Indigenous Allyship Toolkit*, 2020; Nickerson, Marcia, 2019; Robinson-Settee et al., 2021) and as part of broader health equity programing such as Equipping Primary Health Care for Equity "EQUIP" (Browne et al., 2015).

Equipping Primary Health Care for Equity (EQUIP). EQUIP is "an organizational-level, multicomponent health equity intervention" (Browne et al., 2018, p. 3) encompassing cultural safety, trauma- and violence-informed care, and harm reduction approaches. The intervention provides baseline staff education including ICST, along with tailored supports based on the organization's practice context and expressed needs in order to improve care and quality of life for people receiving care(Browne et al., 2015, 2018). The intervention supports change at the individual HCP and system levels with a long term goal to improve experience of the healthcare system for those receiving care, their quality of life and to reduced health inequities at the population level (Browne et al., 2015).

Evaluations of EQUIP through pre-post surveys, interviews, and observations within the clinical setting, reported by Browne et al. in 2018, showed overall increases in care provider's confidence to engage in equity-oriented health care (cultural safety, trauma- and violence-informed care, and equity-oriented care). Browne et al. (2018) reported that the cultural safety component of the program was particularly meaningful for many staff, supporting increased awareness of not only interpersonal but also systemic racism, and associated barriers. Staff

reported increased confidence in their own ability to address "biases, discrimination and prejudices in the clinical setting" (Browne et al., 2018, p. 7). This evaluation of EQUIP shows the potential to incorporate CST into broader programs supporting equity-oriented healthcare to create meaningful change in the care provided, highlighting the need for critical perspectives and reflexivity within individuals as well as within organizational structures in order to create change (Browne et al., 2018).

Indigenous Cultural Safety Training in Occupational Therapy

A search for ICST programs for occupational therapists specifically, identified two self-directed learning packages: *Stories of Paediatric Rehabilitation Practitioners With/In Indigenous Communities. A Guide to Becoming Culturally Safer* (Byrne et al., 2020) and *Enhancing Cultural Humility and Culturally Safer Practices for Indigenous Clients in Occupational Therapy* (Ariano et al., 2021a). Byrne et al. (2020) focus their guide on rehabilitation practitioners working in "non-urban Indigenous communities in Canada" (2020, p. 12). They explored definitions of cultural safety found in the literature, and completed qualitative interviews with rehabilitation practitioners, administrators, and community elders to gain an understanding of practitioners experiences with cultural safety in clinical practice (Byrne et al., 2020). Using stories (qualitative interviews) shared by practitioners working in these communities, Byrne et al. explore the meaning of cultural safety and characteristics of culturally safer practices. The guide provides activities and resources to support rehabilitation practitioners to engage in the critical reflexivity required to move towards culturally safer care, based on the themes found in the qualitative interviews (Byrne et al., 2020).

Ariano et al. (2021a) created a professional development resource for practicing occupational therapists to engage in critical reflections on their own positionality, historical and present harms caused by colonization, and the role of occupational therapists in Truth and Reconciliation. This resource is self-paced and includes some specific activities along with several resources, meant to be reviewed depending on the learning needs of the practitioner (Ariano et al., 2021a). Ariano et al. (2021) provide small units of teaching with each topic area, followed by reflection questions and/or activities to further explore the topic. Several additional resources in the form of booklists, readings, courses, films, and podcasts are listed for exploration. The authors encourage readers to explore the resources at their own pace, either independently or in discussion with colleagues (Ariano et al., 2021a). A limitation of this resources is that Ariano et al. (2021) do not share how the resource was developed beyond indicating that it was reviewed by an advisory panel.

Both of these resources are designed as self-guided packages. The first focusses specifically on rehabilitation practitioners working in Indigenous communities with children and their families (Byrne et al., 2020), while the second is directed to occupational therapists working with Indigenous people in Manitoba (Ariano et al., 2021a). Though both are designed to be self-directed, it would be possible to explore the content with colleagues, generating further discussion and engagement with the content (Ariano et al., 2021a).

A limitation of both resources is that they have not been piloted or evaluated to my knowledge. While Byrne et al. (2020) describe the anti-colonial research process used to develop their guide, Ariano et al. (2021a) do not share their development process. A strength

the resources share is that both groups cite consultation with Indigenous community members or consultants in the development of their materials (Ariano et al., 2021a; Byrne et al., 2020), although Ariano et al. provide little description other than the organization the consultant represents. Either of these guides may be helpful to practitioners to support exploration of their own positionality and understanding of cultural safety concepts, and provide references to supporting literature, however, neither project represents a well-established cultural safety curriculum at this time. Resources used in these guides were gathered from their reference lists and incorporated into the materials for this project.

Organizational Responsibilities in Relation to ICS

While most cultural safety interventions are aimed at individual healthcare providers, organizational and systemic approaches are also required to effect meaningful change to the health inequities experienced by Indigenous people (Balcazar et al., 2009; Browne et al., 2022; Diffey & Lavallee, 2014; Public Health Agency of Canada, 2019). Browne et al. (2022) call on "healthcare institutions and organizations to continue to operationalize plans for accountability, and consider how accountability measures can be built in as organizational aspirations" (Browne et al., 2022).

The Canadian Institute of Health Information (2021)has proposed a framework for measuring cultural safety which lists health system requirements in order to provide culturally safe care. These involve inclusion of Indigenous perspectives in care delivery and planning, policy and procedures directly addressing cultural safety, provision of and mandating staff training, and measuring relevant outcomes to establish accountability processes.

Finally, both post-secondary and health service institutions must work to increase the number of Indigenous healthcare providers working in healthcare in order to create a culturally safer healthcare system (*Honouring the Truth*, 2015; McGibbon, 2019; Rand et al., 2019). Rand et al. (2019) point to research which shows improved recruitment and retention of Indigenous nurses when the educational and healthcare institutions provide culturally safe working and learning environments in which Indigenous healthcare providers feel safe to share their Indigenous identity. It stands to reason that an organization that maintains a culturally safe workplace for Indigenous staff, would also be more likely to provide culturally safe care to the people they serve.

Communities of Practice

Communities of practice (CoPs) are one method used to achieve group learning and improved practice in healthcare professional environments (Barbour et al., 2018; Buckley et al., 2019; Li et al., 2009). CoPs are defined as "groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger et al., 2002, p. 9). While CoPs have not specifically been described in the literature for cultural safety training, they have been described as strategies to further professional education in areas of anti-racism (Shahram et al., 2022) and in developing clinical skills in healthcare fields (Buckley et al., 2019; Camden et al., 2017; Li et al., 2009). In fact, Browne et al. (2009) describe CoPs as one option to explore concepts of social justice among practitioners and to create space for dialogue and knowledge translation around cultural safety.

Describing Communities of Practice

Wenger uses "a social theory of learning" (1998, p. 15) to describe the development of a Community of Practice (CoP): meaning and learning are negotiated among members in the context of a CoP's purpose, shared understanding is developed within the CoP, social engagement within the CoP establishes group norms and collaboration, and personal identity as a member of the group develops through participation in the CoP (Wenger, 1998). While CoPs can be, and often are, formalized within organizational structures, as with apprenticeship and mentorship of students or new professionals, they can also form naturally when groups come together to solve a common problem or intentionally to learn about a chosen topic together (Buckley et al., 2019; Li et al., 2009; Wenger et al., 2002). Communities of practice can include apprenticeship models or instrumental models (also known as intentional learning group models) (Buckley et al., 2019; Li et al., 2009). In apprenticeship model CoPs, learning takes place within the CoP, and membership and level of participation in the CoP changes as an apprentice gains skills and knowledge (Buckley et al., 2019; Li et al., 2009). On the other hand, instrumental model CoPs are often used among more established professionals seeking to problem solve together or develop specific skill sets (Buckley et al., 2019; Li et al., 2009). Buckley et al. (2019) argue that learning theories used will differ depending on the type of CoP established. That is to say an apprenticeship CoP within an organization prioritizes situated learning and gradual integration into the group as the member's skill develops (Buckley et al., 2019; Wenger et al., 2002), while an instrumental CoP focussing on innovation within a specific

practice area or development of a specific skill set emphasizes engagement in the group as a tool for continued learning and problem solving (Buckley et al., 2019).

Effectiveness of Communities of Practice

Three systematic reviews exploring the use and effectiveness of CoPs in healthcare settings find that healthcare related CoPs vary widely in their formation and purpose (Barbour et al., 2018; Li et al., 2009; Ranmuthugala et al., 2011). Additionally, all three systematic reviews note challenges with measuring the effectiveness of CoPs (Barbour et al., 2018; Li et al., 2009; Ranmuthugala et al., 2011).

In 2009, Li et al. completed a systematic review of studies published between 1991 and 2005, examining the definition and use of CoPs within business and healthcare sectors as well as reviewing effectiveness in healthcare studies only. Thirteen healthcare related articles were included in the review. Their findings show that while both apprenticeship and instrumental models of CoP are used in healthcare, quantitative measures of effectiveness were not completed. This lack of quantitative measurements means an overall determination of the effectiveness of CoPs within the review was not possible. Li et al. (2009) identify that CoPs focussed on professional development and practice tend to be less hierarchical than apprenticeship focussed CoPs, allowing for sustained participation from the periphery; healthcare providers could attend the CoP to learn but did not necessarily add to the content.

The second systematic review was completed in 2011 by Ranmuthugala et al., spanning the years 1990-2009. Ranmuthugala et al. (2011) found a proliferation of articles after 2007, with over half of the 33 peer reviewed articles published between 2007-2011. While the

findings of Ranmuthugala et al. support the findings by Li et al. regarding the varied types of CoPs used in healthcare; Ranmuthugala et al. note over time, the purpose of the CoPs evolve from information sharing between professionals toward creating and supporting improvements in practice. Ranmuthugala et al. (2011) found both qualitative and quantitative studies reported improvements associated with the CoPs- such as self-reported practice changes, improvements in meeting specified standards, and development of guidelines and policies; however, due to the complexity of the interventions implemented within the CoPs, most studies are unable to determine if the improvements observed result from participation in the CoPs or other associated interventions. Ranmuthugala et al. (2011) argue future studies must address this measurement challenge by considering the complex natures of CoPs and associated interventions and designing studies to effectively evaluate the specific contributions of CoPs to improvements within healthcare organizations.

The third systematic review assessed twelve peer reviewed papers (10 individual studies and 2 systematic reviews) in order to determine the impact of CoPs on public health practices and identify barriers and facilitators to successful CoP implementation (Barbour et al., 2018). Barbour et al. (2018) completed the review following PRISMA guidelines and used systematic tools to identify the quality of both quantitative and qualitative studies. Like the earlier reviews (Li et al., 2009; Ranmuthugala et al., 2011), Barbour et al. (2018) find the approaches to implementing the CoPs, such as the frequency and format of meetings and the duration of CoPs, vary widely. Reported outcomes of the CoPs studied include organizational and systemic impacts, such as improved staff retention, increased availability of practice resources, and

policy and program changes (Barbour et al., 2018). Like the other reviews, self-reported improvements in knowledge and confidence have been found (Barbour et al., 2018; Li et al., 2009; Ranmuthugala et al., 2011) as well as increased engagement in advocacy and collaboration activities (Barbour et al., 2018). The authors find that measurements must move beyond self-report measures in order to provide more robust evidence of the impact of participation in CoPs on healthcare provider practice and ultimately health outcomes of the people receiving care (Barbour et al., 2018)

Barbour et al. (2018) add valuable information about enablers and barriers to implementation of CoPs to the literature. Enablers include participants safety and comfort in the environment and with the facilitators, clear meaningful learning goals, and establishing connections between the group members- including the presence of fun in the CoP, frequency of contact, and the ability to problem solve with each other (Barbour et al., 2018). Barriers to successful CoP implementation related to the absence of enablers include insufficient time for discussion, insufficient length of CoP, poor facilitation, and limited ability to build networks due to the makeup of the CoP membership- too many pre-existing established relationships or limited active participation from CoP members (Barbour et al., 2018).

These three systematic reviews share progressively more compelling evidence that CoPs can support knowledge translation in healthcare (Barbour et al., 2018; Li et al., 2009; Ranmuthugala et al., 2011) and practice change (Barbour et al., 2018; Ranmuthugala et al., 2011). While the earlier reviews were unable to clearly show effectiveness resulting from CoPs on practice (Li et al., 2009; Ranmuthugala et al., 2011), later studies show positive impacts on

professional practice and organization level measures such as staff retention and policy changes (Barbour et al., 2018). However, CoP participant self-report continues to be the dominant measure of effectiveness, making objective improvements to the care of individuals difficult to establish (Barbour et al., 2018; Ranmuthugala et al., 2011). Barbour et al. (2018) and Ranmuthugala et al. (2011) suggest more sophisticated evaluation plans are needed in order to truly measure the impact the healthcare providers' participation in a CoP has on health outcomes of individuals receiving care.

Community of Practice for Anti-Racism Training

One study published after the systematic reviews described above relates more closely to my proposed study of continued engagement with ICST for occupational therapists. Shahram et al. (2022) created and evaluated a five-session online anti-racism CoP for physicians and faculty at a university, called the Tea House Series. Curriculum was developed based on the following four pillars: using a "pedagogy of critical consciousness" (Shahram et al., 2022, p. 2319), providing local examples of health inequities, creating a welcoming space for interaction and establishing accountability (Shahram et al., 2022). Shahram et al. (2022) evaluated the CoP outcomes using both qualitative and quantitative responses on short pre- and post-session questionnaires. Participants were also asked to create a personal measurable goal at the beginning of each session although these personal goals were not evaluated within the study (Shahram et al., 2022).

Qualitative outcomes of the study are expressed in themes of: initial feelings of being overwhelmed, developing a sense of community, expressing intention to take action as the CoP

progressed, being motivated by seeing the local health equity and oppression data, and frustration at a lack of resources to address systemic racism (Shahram et al., 2022). Quantitative outcomes of the CoP show increased confidence of participants to achieve the learning objectives for each session using pre- and post-Likert scale responses (Shahram et al., 2022). Shahram et al. (2022) describe plans for a future study of participant developed goals, exploring strategies the participants intend to use in their workplaces. The authors also plan to expand the Tea House Series to include other health professional schools within their program, such as nursing, rehabilitation, and dentistry programs (Shahram et al., 2022). One limitation I noted in this study is the lack of evaluation of the quantitative data beyond reporting change in aggregate responses, making it unclear if the change in confidence of participants described is statistically significant or not.

Rationale for Study

Indigenous people experience negative health consequences as a result of racism, prejudice and biases within the healthcare system and those working within it (Allan & Smylie, 2015). For healthcare providers and student healthcare professionals, ICST has been shown to increase self-awareness, and reflexivity about their own positionality, privilege, and power, and improve confidence in addressing biases, racism and discrimination in the healthcare setting (Browne et al., 2021; Diffey & Mignone, 2017; Mills et al., 2022). It is theorized that this in turn improves: communication between healthcare provider and individuals receiving care, their satisfaction and engagement with health interventions, and health outcomes of racialized groups with some emerging evidence to support these claims (Henderson et al., 2018).

Culturally safe care is an outcome experienced, or not, by the receiver of care (Churchill et al., 2017; Gerlach, 2012; Papps & Ramsden, 1996; Ramsden, 2002). In order for culturally safe care to exist, healthcare providers must engage in ongoing reflection about their own positionality, values, and beliefs and take action to build trusting relationships, share power and take action to address interpersonal and systemic racism (Allan & Smylie, 2015; Diffey & Lavallee, 2014; Wylie et al., 2021). As described in the literature review, there are varied approaches to providing Indigenous cultural safety training to healthcare providers including one-time workshops, workshop series, community immersion opportunities and self-directed toolkits (Browne et al., 2021; De Leeuw et al., 2021; Herzog et al., 2021; Mills et al., 2022; Yaphe et al., 2019). Resources for engagement with ICST over a longer term, however, remains limited

to self-directed toolkits or personal initiative (Ariano et al., 2021a; Byrne et al., 2020; *Indigenous Allyship Toolkit*, 2020).

The literature lacks information on strategies that healthcare providers can employ to engage in continuous cultural safety learning and development, especially for those that do not work directly in Indigenous communities as part of their role. This study will explore the use of a community of practice (CoP) to support prolonged engagement with core components of cultural safety for pediatric occupational therapists. Pediatric occupational therapists will be the focus of the study, exploring their engagement with Indigenous cultural safety through the use of a community of practice model.

Aim and Research Questions

Using constructivist and Indigenist (Hughes et al., 2022; Rix et al., 2019) epistemologies, this narrative inquiry explored how participation in a cultural safety CoP influenced urban, pediatric occupational therapists on their journeys to becoming culturally safer, anti-racist occupational therapists.

Research Questions

1. What changes in attitudes and beliefs, in relation to cultural safety, resulted from participation in the CoP?
2. What personal and practice changes did the participants report as a result of participation in the CoP?
3. How did the CoP model impact participants on their journey to becoming culturally safer occupational therapists and what are the strengths and limitations of this approach?

Epistemology

I applied constructivist (Creswell, 2014; Crotty, 1998) and Indigenist epistemologies (Hughes et al., 2022; Rix et al., 2019) to conceptualize this research study. Constructivists acknowledge that there is no universal reality, rather multiple interpretations of reality dependant on one's social location and experiences (Crotty, 1998). Knowledge or meaning is created through human social interactions with the world, and thus, different observers will ascribe different meanings based on their past experiences (Creswell, 2014; Crotty, 1998). Meaning is socially and historically constructed and conveyed through the language and symbols used, and patterns of interactions (Creswell, 2014; Crotty, 1998). The meaning assigned to experiences vary based on the person experiencing the interaction (Crotty, 1998). The goal of the research is to gain an understanding of the varied meanings ascribed to the observations, in order to gain a rich understanding of the phenomenon being studied (Creswell, 2014).

The researcher is not separate from the research, but influences the research through their choice of research questions and methods utilized to answer those questions (Creswell, 2014). Acknowledging the influence of the researcher on the participants and outcomes of the research fits well with the constructivist as well as the Indigenist epistemology (Hughes et al., 2022; Rix et al., 2019) grounding this study.

While traditional Western approaches to research view knowledge as being earned or possessed by individuals, Indigenous epistemologies view knowledge as relational, co-constructed through relationship with people but also with all of creation and with the

concepts themselves (S. Wilson, 2001). Shawn Wilson, an Indigenous scholar and the author of *Research is Ceremony* (2008) highlights the importance of the researcher's intention for the research. Wilson (2008) states that beginning with good intentions and working in a circular way, where understandings are brought back to participants in order to maintain reciprocity, relationship, and accountability, are central to Indigenous epistemology. Wilson (2008) points out that all aspects of the research including choice of topic, methods for gathering data, analysis and sharing the results must maintain a circular path, returning to the participants and community to give back to the community and participants and maintain relationship, reciprocity, and accountability.

Indigenist methodology is used by non-Indigenous researchers when engaging with subjects affecting Indigenous people (Rix et al., 2019). The researcher must be mentored and supported by Indigenous Wisdom Keepers, Elders, and/or communities (Rix et al., 2019). Using research methods that align with, and centre Indigenous ways of knowing and being, the researcher acknowledges their own positionality and focuses on relationships with individuals, communities, and reciprocity in the research process (Hughes et al., 2022; Rix et al., 2019). The researcher must give back to the community in some way, through service, research products, or results (Hughes et al., 2022; Rix et al., 2019; S. Wilson, 2008).

Although non-Indigenous researchers cannot work from an Indigenous epistemology as they do not share the underlying knowledge and worldview, they can use an Indigenist approach, meaning they can work in ways that align with Indigenous worldviews and maintain accountability to Indigenous communities affected by the research (Rix et al., 2019; S. Wilson,

2001, 2008). In an Indigenous worldview, research is a ceremony requiring preparation and follow-up and must be accompanied by mentorship from Indigenous researchers (Hughes et al., 2022; Rix et al., 2019; S. Wilson, 2001). Given that the overarching goal of this project was to create culturally safer healthcare experiences for Indigenous children and their families this methodology is appropriate. My role as the researcher was to learn with the participants and remain accountable to Indigenous families for the resulting work, ultimately working towards culturally safer care for Indigenous people.

In this research I sought mentorship from Wisdom Keeper, Grandmother Dr. Mary Wilson who sat on my advisory committee. She helped me to centre the needs of Indigenous families for culturally safer healthcare and to incorporate a personal ceremony into my research process. For me, the ceremony included morning meditation to ground me and set my intention for the work. I worked to include the natural world in my routine each day, spending time outside, usually walking, observing and *being* in nature, i.e., Mother Earth. At Grandmother Mary's suggestion, I journaled my observations and the lessons I gained to support my learnings from the natural world and to sensitize me to relationship in my academic observations and processes. I shared my questions and observations with Grandmother Mary to ensure I kept Indigenous ways of knowing and being centred and proceeded in a "good way". Through my relationship with Grandmother Mary and inclusion of Indigenous Wisdom Keepers and community members in the CoP, I worked, and continue to work, to remain accountable to Indigenous ways of knowing, being, and doing.

Conceptual Framework

The Cultural Safety and Trauma- and Violence-informed Care Framework for Redressing Inequities in Healthcare Access (i.e., the Cultural Safety Framework) (Horrill et al., 2021) was used as a guide for both the content of the community of practice and in the analysis phase of the study. The Cultural Safety Framework describes a pathway towards cultural safety and trauma- and violence-informed practice that addresses healthcare provider actions at the intrapersonal, interpersonal, and contextual or societal levels (Horrill et al., 2021). This model is built on the foundations of EQUIP, an established system level, equity oriented health care approach which was developed in partnership with Indigenous led agencies (Browne et al., 2015, 2018; Horrill et al., 2021). EQUIP includes both cultural safety and trauma-informed care components in its content (Browne et al., 2015, 2018; Horrill et al., 2021). Evaluations of EQUIP have shown to increase healthcare provider self-awareness (i.e., reflexivity), confidence in addressing issues of discrimination and bias in the workplace, and action towards addressing racism and structural barriers within the healthcare environments (Browne et al., 2018).

Horrill et al. (2021) propose this framework as a provider level tool to support nurses to address barriers to care and integrate cultural safety and trauma- and violence-informed care (TVIC) concepts into their individual practices. The Cultural Safety Framework divides culturally safe and TVIC into 3 domains: Intrapersonal Domain (Reflexivity), Interpersonal Domain (Relationship), and Structural Domain (Context) (Horrill et al., 2021). Each domain includes guiding questions for the practitioner to consider at that level without dictating specific actions (Horrill et al., 2021). In clinical practice, the practitioner begins with the first domain by

reflecting on how their positionality, their attitudes and beliefs impact the people to whom they are providing care. The second domain addresses interpersonal relationships. This domain focuses on relationship building, collaboration, power-sharing and anti-racist actions. The third domain focuses on the context of the individual receiving care, including the historical context of intergenerational trauma caused by colonialism and residential schools, and individual contexts due to social, economic, and/or structural barriers. Practitioners are encouraged to address the contextual barriers by linking individuals to available resources. Additionally, in this domain, practitioners are encouraged to engage in truth and reconciliation activities, participate in ceremony and advocate for systemic change. Each domain builds on the foundation laid in the previous domain, expanding the practitioners' focus from a focus on themselves, to their relationship with the individual receiving care, then onto the system, in order to support culturally safe, equitable healthcare for the individual (Horrill et al., 2021).

The Cultural Safety Framework (Figure 1) reflects the journey of becoming a culturally safer practitioner. It highlights key aspects of cultural safety including: reflexivity, focus on relationship, and contextual awareness (Horrill et al., 2021) and each of the core components of cultural safety discussed in the literature review can be mapped onto this model (see Table 2). The Cultural Safety Framework considers structural and relational barriers to healthcare, encouraging a wider gaze than that of the individual healthcare providers and providing an external structure to review and evaluate one's own practice. While the Cultural Safety Framework was developed with a focus on nursing practice, the personal, interpersonal and systemic barriers present in nursing practice environments (Horrill et al., 2021) also exist in OT

practice (Beagan et al., 2022; Gerlach et al., 2018; White & Beagan, 2020), making the Cultural Safety Framework relevant to OTs seeking to provide culturally safer care.

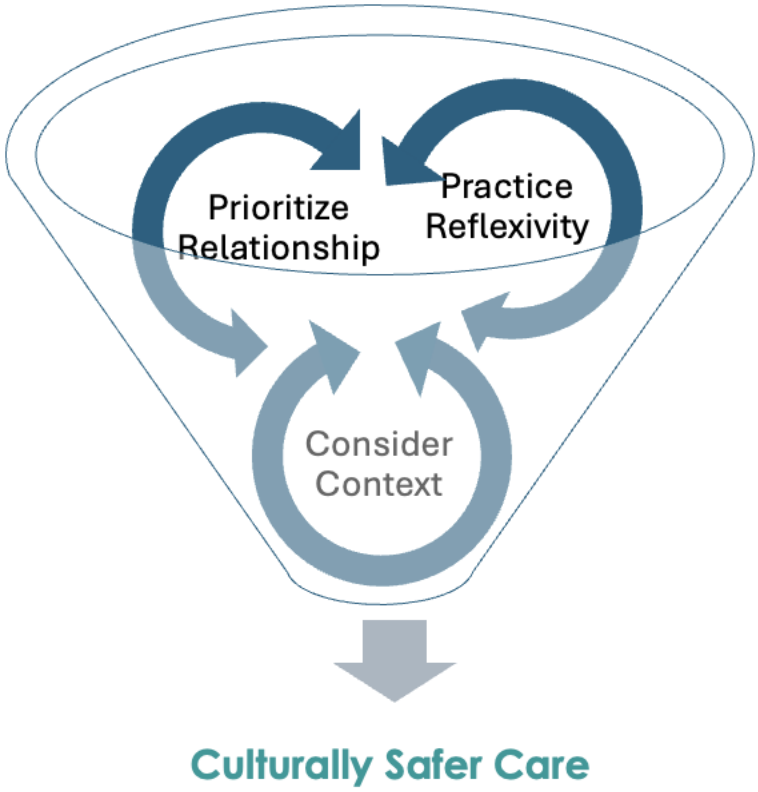

Figure 1 Adaptation of Cultural Safety and Trauma- and Violence- Informed Care Framework (Horrill et al., 2021)

Table 1

Framework Domains and Corresponding Core Components of Culturally Safe Care

Domains of the Cultural Safety Framework (Horrill et al., 2021)	**Core components of culturally safe care**
Intrapersonal Domain: Practice Reflexivity Reflect on personal values, beliefs, and positionality	Reflexivity
Interpersonal Domain: Prioritize Relationships Relationship building, collaboration, power sharing and anti-racist actions	Relationship Focused Power Sharing Anti-Racism
Structural Domain: Consider the Context Consider individual's historical and current context	Contextual Awareness

In this research project, I used the Cultural Safety Framework (Figure 1) to develop interview guides, shape content of the CoP, and guide data analysis. When using the Cultural Safety Framework in the CoP setting, rather than a one-to-one relationship between healthcare provider and individual receiving care for which it was developed, we attempted to follow the linear order of the domains as presented by Horrill et. al (2021), however moved between the domains and associated content to assist with participants understanding and reflection. For example, discussion and education around contextual awareness was presented earlier in the CoP (rather than as the final topic) to provide opportunities to reflect more broadly on the impacts of colonization on Indigenous clients and consider how those impacts may influence engagement in healthcare relationships. Anti-racism content was interwoven throughout several sessions of the CoP, to support participants' reflection on their own positions of privilege within a colonial health system (Beavis et al., 2015). The Cultural Safety Framework was useful because it provided a structure for discussion. While the funnel visual ultimately

chosen for the Cultural Safety Framework depicts the flexible order of the content, each domain offers a focal point and guiding questions to support the development of the associated core components. For example, reflexivity (a core component) is addressed in the intrapersonal domain, meaning that the healthcare provider must consider their own personal characteristics, attitudes and beliefs; whereas relationship, power sharing and anti-racism components correspond to the interpersonal domain, necessitating consideration of interactions between the healthcare provider and the individual receiving care.

Methodology

I used narrative inquiry to explore the perceptions of urban pediatric occupational therapists on how their participation in an Indigenous cultural safety community of practice (CoP) affects their engagement with cultural safety in their own practice. Narrative inquiry is a qualitative methodology in which participants share their own experiences of an event with little prompting from the researcher in order to allow the participant to emphasize the experience in a way that is most meaningful to them (Ollerenshaw & Creswell, 2002). The researcher then gathers the stories as data, analyses the data for common and divergent themes, combining and rebuilding the participants' stories to form one or more re-storied common experiences (Ollerenshaw & Creswell, 2002). The stories are rebuilt and interpreted with attention to shared meaning, chronological order, social interactions, and context (Barton, 2004; Ollerenshaw & Creswell, 2002).

Barton (2004) argues narrative inquiry is a relational approach to research emphasizing relationship building while sharing and co-constructing stories. This inclusion of relationship fits well with Indigenous ways of knowing and being and the Indigenist epistemology used in this study (Barton, 2004; Rix et al., 2019).

Methods

Setting

In this qualitative study a 6-session cultural safety CoP for pediatric occupational therapists was developed to encourage participants to engage in shared learning about Indigenous cultural safety. I held the dual roles of researcher and co-facilitator/ participant in the CoP. Participants were aware of my engagement in the CoP sessions at the outset and a cofacilitator was hired to support me and the group as I carried out these dual roles.

I used an instrumental CoP in this study, using the CoP to support collaboration and skill development related to Indigenous cultural safety among pediatric occupational therapists. I applied the findings of the CoP studies described in the literature review, particularly using strategies such as building a sense of community and safety along with trained facilitation to support establishment of a successful CoP (Barbour et al., 2018; Shahram et al., 2022). Curriculum for the CoP was guided by the Cultural Safety Framework (Horrill et al., 2021) and core components of ICST found in the literature (Bourassa et al., 2020; Browne, 2017; Chakanyuka et al., 2022; Goodman et al., 2017; Papps & Ramsden, 1996; Ward et al., 2021). Exercises and practice tools shared in published ICST resources, grey literature and the personal libraries of my advisors, the co-facilitator, and my own library were used to customize the content of the CoP to meet the learning needs of participants, as expressed during their initial interviews. We encouraged co-creation of the curriculum by asking participants to share materials from own experiences and libraries as they felt comfortable. Only one participant shared resources with the group during the CoP however some participants continued to share

resources and events with each other following the completion of the CoP via email. Resources developed or endorsed by Indigenous researchers or communities were prioritized, as will resources based on research evidence. An outline of the curriculum can be found in Appendix A.

The CoP employed a trained facilitator to support learning and engagement in in-person meetings every three weeks. The trained facilitator has a Masters of Social Work degree and is a contributing author to the Valuing All Voices Framework (Roche et al., 2020) used in community based research at the Centre for Healthcare Innovation. The Valuing All Voices Framework was designed to support meaningful, inclusive, and trauma-informed community engagement in research (Roche et al., 2020; Shimmin et al., 2017). This model of facilitation was used for the CoP and supported the creation of a safe space for participants to engage in critical reflection and learning (Barbour et al., 2018). The trained facilitator and I co-facilitated the CoP. The trained facilitator's role focused on the group process and safety including: help planning the agenda, opening and closing the sessions, facilitating activities, monitoring group process, and supporting a safe learning environment. My role was to prepare content for the sessions, invite Indigenous Wisdom Keepers and teachers, engage in the group learning environment, incorporate participants' feedback and resources into the sessions and implement the research plan components. Both facilitators worked to model accountability and ask probing questions to facilitate deeper discussion during the CoP sessions.

Each meeting was held in person at the University of Manitoba Bannatyne campus and lasted approximately 90 minutes. Participants unable to attend due to illness, were able to join

virtually on two occasions, using Microsoft Teams platform. Meetings focused on core concepts of ICST and included Indigenous Wisdom Keepers and community members in three sessions to centre Indigenous knowledge, experiences, and contexts. Curriculum was prepared in advance, and adapted to meet participants' needs and feedback from the co-facilitator and Indigenous guest speakers as the sessions progressed. A reflexive question and readings for the following session was emailed to participants after each CoP session. Participants were asked to journal their reflections about the questions between CoP sessions (Appendix B). These questions were intended to support deeper engagement with the content and reflection on how participants could integrate learnings into their OT practice.

Participants completed an initial semi-structured one-on-one interview prior to the CoP series and a final interview after the series is complete (Appendix C). Each CoP session (excluding the first) began with a check-in, modeled after a sharing circle. Primed by the reflexive journaling question (Appendix B), the group reflected on previous learning, successes, struggles, and questions that arose during the intervening weeks. While these sessions were initially planned for 15 minutes, they extended longer and lead to group discussion most sessions. The story of each participant's learning journey (the data) was gathered through the semi-structured interviews and participants' contributions during the check-in component of the CoP.

Sampling and Recruitment

Health Ethics Review Board (HREB) approved the study prior to recruitment of participants (HREB # HS26023 (H2023:175) (Appendix D). Invitations to participate in the study

were broadly circulated among pediatric occupational therapists working in the capital region of Manitoba. Invitations were distributed through the provincial occupational therapy professional association's email distribution list, social media posts, and personal invitations. Recruitment email and social media posts are shown in Appendix E.

All occupational therapists that responded to the invitation (6) were invited to join the study. Had maximum capacity of the group been reached (8), purposeful sampling would have been used select participants and maximize diversity in areas of gender, ethnicity, race, and years of OT practice (Cohen & Crabtree, 2006; Creswell, 2014). The small group size was chosen to allow for the deep participation and discussion necessary to engage with the learning material (Browne et al., 2021; Yaphe et al., 2019).

Eligibility criteria

Inclusion Criteria

Occupational therapists working in Winnipeg and the surrounding area were included if they: (a) worked primarily with children and their families (self-report), (b) had at least three months experience in their current position, (c) worked a minimum two days per week and carried a clinical caseload with approximately 20% Indigenous families (self-report), and (d) were willing to participate in six, in-person Indigenous cultural safety CoP meetings scheduled approximately every three weeks, complete reflexive journaling between sessions, and participate in two interviews. No previous Indigenous cultural safety training was required to participate in the study.

In the spirit of “nothing about us, without us”, self-identified Indigenous occupational therapists were not excluded from participation; however, a plan was in place to provide additional supports to prioritize the psychological safety of Indigenous participants (Churchill et al., 2017; Ward et al., 2021). No Indigenous occupational therapists volunteered for the study.

Exclusion Criteria

Occupational therapists who have worked exclusively in Indigenous communities for one year or more (e.g., in Jordan’s Principle program) were excluded due to their ongoing access to ICS training and initiatives in their daily work. Interested OTs who could not attend in-person CoP meetings were excluded from the study.

Screening and Consent

Potential participants were provided with an opportunity to ask questions about the study and requirements of participants were provided during a screening phone call to determine eligibility (Appendix F). The Participant Information and Consent Form (Appendix G) were sent to those interested in participating via email and an appointment for an initial interview at the location of their choosing (their home or an office on the university campus) was set.

Before commencing the interview, I reviewed the Participant Information and Consent Form (Appendix G) including risks and benefits of participation and answered any questions potential participants had. They were reminded that they could withdraw at any point and of the list of resources available should they find the material distressing. Due to the nature of the CoP: discussion of sensitive matters such as historical trauma, racism, personal beliefs; there

was potential to trigger strong emotional reactions. Resources were provided in the form of a handout with information on how to access free in-person and online mental health supports (*Counselling & Resources Available during COVID-19*, n.d.). After signing the Participant Information and Consent Form, participants were provided with an e-gift card which was meant to cover parking expenses while participating in the CoP.

Data Collection

Data gathered and included in the analysis included two one-on-one semi-structured interviews with each participant (one prior to the participation in the CoP and the final interview completed after the sixth CoP session), group check-in portion of the CoP sessions, researcher field notes, and reflexive memos (Table 3). Consistent with narrative inquiry methods, interviews began with an open-ended question, asking participants to share the story of their journey towards cultural safety, in order to allow participants to highlight aspects of the story that were most meaningful to them (Ollerenshaw & Creswell, 2002).

Table 2

Timing and Type of Data Collection

Timing of data collection	**Data collection method**	**Data source**
Prior to initiation of community of practice (CoP) series (within one month)	Initial interviews (one-to-one)	Participants
	Field notes	Researcher
Beginning of each CoP session (range of 15-90 minutes)	CoP check-ins based on reflexive journaling activity	Participants and researcher
Following each CoP session	Debrief discussion following each CoP session	Researcher and co-facilitator
	Field notes, reflexive memos	Researcher
Following completion of CoP series (within one month)	Final interviews (one-to-one)	Participants
	Field notes	Researcher

The interviews and check-in sessions were digitally audio-recorded and transcribed using University approved transcription software. Verbatim transcription was used to maintain the authentic voice of participants (Ravitch & Carl, 2021). Following transcription, I listened to the audio-recordings while reading the transcripts to check the accuracy of the transcription and clarify any sections of text that were inaudible. I replaced personal identifiers with pseudonyms in the transcript. This initial review of the transcripts allowed for early immersion in the data and helped to refine the interview guide for subsequent participants (Ravitch & Carl, 2021).

Additional data was gathered through dialogue with the co-facilitator, field notes and reflexive memos. Immediately after each interview and CoP session, I wrote field notes to document my initial impressions and the non-verbal and contextual cues within the CoP session, supplementing the audio recordings and documenting the overall group process along with any striking insights developed within the group. I met with the co-facilitator to debrief about the session's main themes, challenges, insights, and support critical reflection on the session. These conversations were digitally audio-recorded and transcribed to form part of the data set. These additional data collection methods are a form of data triangulation which support trustworthiness of the data (Ravitch & Carl, 2021). I used dialogical engagement with my advisor and my co-facilitator throughout the research process to examine my dual role as CoP participant and researcher, group processes and insights, and to support my own critical reflections on the process and content of the research.

Data Analysis

Data analysis was completed in two phases. The first phase was an iterative process, beginning as data was collected. Guided by directed content analysis, this phase included immersion in the data and initial coding, using the cultural safety framework to establish initial codes. Directed content analysis is an established approach "used to interpret meaning from the content of text data" (Hsieh & Shannon, 2005, p. 1277). NVIVO qualitative data analysis software was used to organize the data for analysis. The second phase was initiated as data collection and coding neared completion. In the second phase, I reviewed the data for each participant, paying attention to the themes that arose within each participants' stories of their journeys as well as common themes between participants' stories. I then re-organized them into chronological order to show the story of each participants' journey and describe themes that arose across participants.

Dialogic engagement with members of my advisory committee, which includes occupational therapists, qualitative researchers, and an Indigenous Wisdom Keeper, was used throughout the data analysis phases to review emerging coding definitions, challenge my interpretations of the data and gain a broader perspective on the analysis, supporting rigour of the study (Ravitch & Carl, 2021). My advisor reviewed raw data in order to form her own understanding of the data and provide more robust dialogic engagement around data coding and emerging themes, challenging my reflections and assumptions (Ravitch & Carl, 2021).

Phase One: Directed Content Analysis

Directed content analysis acknowledges that researchers enter analysis with prior knowledge including existing research, theories or frameworks which inform the study (Hsieh & Shannon, 2005). This approach to analysis helps to sensitize the researcher to the established theories or frameworks, while allowing new insights to be formed from the content of the data, as such both deductive and inductive codes are used (Hsieh & Shannon, 2005).

Directed content analysis is known to identify both themes and disconfirming cases, which supports rich data analysis (Hsieh & Shannon, 2005). A limitation of directed content analysis is the potential to bias the researcher in favour of the previous research and the predetermined codes (Hsieh & Shannon, 2005). This limitation was addressed through: dialogic engagement with my advisory committee members throughout the data analysis process, initial immersion in the data, and use of an audit trail to track evolving code definitions (Hsieh & Shannon, 2005; Ravitch & Carl, 2021).

As is common in qualitative research, I began analysis as data was collected, immersing myself in the transcripts, field notes and memos through multiple readings (Ravitch & Carl, 2021). NVIVO qualitative data analysis software was used to organize data for analysis. I completed initial coding based on the Cultural Safety Framework and codes emerging directly from my research questions while remaining open to additional inductive codes that arise from the data (Hsieh & Shannon, 2005; Ravitch & Carl, 2021). Additional codes were created to describe any data that remained uncoded, or to capture new/ unanticipated concepts arising from the data following the first round of coding (Hsieh & Shannon, 2005). The iterative nature

of this data analysis, as data is being collected, supported my immersion in the data and provided opportunities for the emerging data to inform content of the CoP sessions (Ravitch & Carl, 2021). Regular meetings were held with my advisor to compare codes assigned, discrepancies were discussed to ensure consistency of coding and refine definitions of codes. Dialogic engagement with my advisor occurred regularly during this process to challenge my perspectives and offer alternative interpretations (Ravitch & Carl, 2021).

Table 3

Codes and Definitions Used During Data Analysis

Code	**Definition of code**
Power	awareness or description of power dynamics in relationship
Relationship	building connection to individual/family/community
Strengths based	focusing on the strengths of the individual/ family receiving care. Includes identifying family as expert in their own experiences.
Racism	Participant is describing racism they observed or participated in or had pointed out to them. They may not explicitly label it as racism themselves in the interview.
Positionality	Identifying one's own social position, unearned privileges, power. Can include identifying own race, ethnicity, and socioeconomic position in society.
Reflexivity	participant examining their own impact

Trauma informed	describing trauma informed care approaches
Historical context	Awareness of historical contexts including colonization, residential schools and 60's scoop impacts
Legislative and policy context	modern day legislation and policies impacting Indigenous people
Participation in ceremony	Engaging in Indigenous Ceremonies or learning about Ceremonies- Part of context in the ICS model
Socioeconomic context	Part of Structural Domain- socioeconomic context experienced by Indigenous clients- includes systemic racism, economic barriers and discrimination, intergenerational trauma
Beginning of CS journey	Start of participants journey towards culturally safer care
CoP Considerations- Goals for CoP	goals participants state for participation in the community of practice
CoP Considerations- Learning needs	areas identified for further learning by participant during interview
Values and beliefs	Participant identifying their own values and beliefs
Awareness of world views	Awareness that multiple world views exist and difference between them
Becoming unsettled	The feeling of/ willingness to feel discomfort in order to learn and grow. Can include uncovering our own biases
Definition	How participant defines Indigenous cultural safety
Experience of CoP	Participants' thoughts on their experience in the CoP sessions
Planned actions	Actions planned following the CoP. Continuing the journey.

Recommendations for future CoP-Content	Recommendations for future content
Recommendations for future CoP-Format	Recommendations around format of future learning
Recommendations for future CoP-People	Ideas for how to include other people in future sessions

Upon completion of the data collection (following transcription of the final interviews), I re-immersed myself in the data, re-reading transcripts, field notes and memos in chronological order, to reorient myself to the data as a whole (Ravitch & Carl, 2021). Additional rounds of dialogic engagement with my advisor and/or committee was completed following this re-immersion in the data, before proceeding to phase two.

Phase Two: Narrative Inquiry

During the second phase of data analysis, I organized the coded data in two ways. The first was to illustrate the individual learning journey of each participant, to explore the individual learning in relation to their own context and in relation to their experience within the CoP. The second way was organizing the data into themes to represent the learning of collective group in relation to the Cultural Safety Framework within the context of the CoP. In both instances, to address the research questions and synthesize the findings, I looked at the data within and across codes, re-naming, collapsing and or eliminating codes to best represent the data.

In this process, I re-read the data, following each participant's story throughout the study period, in order to understand the individual stories of the participants (Ollerenshaw &

Creswell, 2002; Ravitch & Carl, 2021). I developed individual case summaries for each participant to support my understanding of their journeys with cultural safety and how they changed over time. Using narrative inquiry as the lens, I explored structural components of participants' stories including: (a) personal experiences and social interactions, (b) change over time and future intentions, and (c) situational context (Barton, 2004; Ollerenshaw & Creswell, 2002). I viewed data individually for each participant in order to highlight individual participants' change over time, as well as across all participants in order to illuminate common and divergent themes (Ollerenshaw & Creswell, 2002; Ravitch & Carl, 2021).

Consistent with narrative inquiry, I reorganized the participants' narratives into chronological order, highlighting individual themes-(Ollerenshaw & Creswell, 2002). Each participant's story was rich and unique, for this reason they were not combined, rather each individual "re-storied" version of participants' journeys towards cultural safety was shared with them so that they could review the stories and provide feedback. This form of member checking confirms that the results resonate with participants' experiences and supports trustworthiness (Ravitch & Carl, 2021). The stories of participants journeys are shared first in the finding section to help the reader get to know the participants and their experiences.

Throughout the second phase of analysis and interpretation I continued to engage with my advisor and committee members to question my interpretation, consider alternative interpretations, and reflect on my biases and possible omissions in analysis (Ravitch & Carl, 2021). This practice supported my own critical reflexivity and was essential given my dual role as participant and researcher within the CoP.

Strategies to Enhance Trustworthiness, Rigour, Accountability, and Authenticity

Indigenous scholar Shawn Wilson (2008) describes Indigenous concepts of trustworthiness and rigour in terms of accountability, relationality and authenticity. Researchers must remain accountable to the community affected by the research, authentically represent the participants' stories and finding, and ensure that they fulfil their role in the research relationship by giving back to the wider community through the research findings or products (S. Wilson, 2001, 2008). I have attempted to comment on both constructivist and Indigenist approaches to these concepts in this section.

Strategies to enhance the study's rigour, trustworthiness, accountability, and authenticity were considered throughout the study development, implementation, analysis and reporting of the results. Acknowledging my positionality, relationship to, and investment in the research as both a participant in the CoP and researcher clearly acknowledges my standpoint and intentions for the research. This transparency supports trustworthiness in constructivist epistemology and relationality and accountability in an Indigenist research paradigm (Ravitch & Carl, 2021; Rix et al., 2019; Smith, 2012; S. Wilson, 2008).

Dialogic engagement with the advisory committee members was used throughout the research process (Ravitch & Carl, 2021). Dialogic engagement was used to challenge me to consider my assumptions and broaden my perspective when making decisions about the research study and during coding and analysis to consider alternate interpretations (Ravitch & Carl, 2021). Engagement with my advisory committee in this way was particularly important given my dual role as participant and researcher.

Multiple data sources including researcher field notes and reflexive memos, participant interviews and CoP check-ins were used to gain a well-rounded view of the participants' (and my) cultural safety journeys. Including multiple data sources "encircles" (S. Wilson, 2008, p. 101) the participants' experience creating a well-rounded view of participants' cultural safety journeys and contributes to the authenticity of the results (Indigenist) and supports the rigour of the study (constructivist). Verbatim transcription and use of direct quotes from participants in the analysis supports authenticity and trustworthiness of the study findings by highlighting the participants' stories in their own words (Ravitch & Carl, 2021; S. Wilson, 2008).

The stories developed through analysis and retold by myself, the researcher, were provided to the participants to review and provide feedback about authenticity of the interpretations. This method supports both accountability from an Indigenist perspective and contributes to trustworthiness within the constructivist epistemology.

Ethical Considerations

While anti-Indigenous racism and culturally unsafe care impacts Indigenous people, Strega and Brown (2015) have emphasized the need to focus researchers' gaze on the perpetrators of harm rather than on the individuals being harmed. This research aimed to support occupational therapists to increase their understanding of, and skills in providing culturally safer care, thus reducing the harms perpetrated during interactions between occupational therapists and Indigenous families.

Throughout the project, I have sought guidance, support and ongoing engagement from Grandmother Mary Wilson, a Wisdom Keeper experienced in pediatric healthcare. She assisted

me to reflect on my approach to the study and to proceed with the project in a way that respects and acknowledges the strengths of Indigenous communities without causing additional harms. Grandmother Mary helped to ensure the emotional and spiritual safety of our invited guests by offering her support outside the CoP as needed.

Findings

Six occupational therapists working in pediatric practice agreed to join the study. Participants all identified as White women ranging in age 35-59 years of age with years of practice ranging from 3-20+ years of practice. One participant identified as having a disability. All six participants completed the initial interview and first CoP session, after which one participant withdrew due to challenges with physical health and family demands. The remaining five participants completed the entire study.

Findings are presented first with the re-storied experiences of individual participants, and then thematically, framed with the Indigenous Cultural Safety Framework. I begin with the re-storied experiences so that the reader can get to know the participants before proceeding to exploration of the themes expressed in the data.

Stories of Participants Journeys Towards Culturally Safer Care

Each participant's story is presented to include their positionality, their understanding of cultural safety and their journey leading up to and during the CoP, followed by their plans for next steps on their journey.

Lena's Journey: Listening Differently

Lena is a first-generation Canadian woman of Eastern European ancestry in her mid-late 50's. She described her personal values as service to others, access to housing, structure and meaningful employment. "The importance of home. Yeah. And, and having meaningful work. And, you know, giving back, volunteerism, and participating in meaningful kinds of things in the community. Yeah, I, that's something that I think is really important. Having adequate food,

having structure and routine" (Lena, initial interview). Lena is the mother of three adult children. She lost both her parents when her children were young. Her small extended family helps her empathize with some Indigenous parents who do not have parenting role models to turn to.

Lena has more than 20 years' experience working as a pediatric occupational therapist. She works with preschool children from a variety of backgrounds. She provides direct treatment as well as screening phone calls to determine families' needs, priorities and possible supports available. Outside of her occupational therapy work, Lena is a Trustee on the Board of Trustees for a rural school division and is a volunteer coach with Special Olympics.

Lena's journey towards cultural safety in her practice began in the last few years with a mandated course on Indigenous Cultural Safety through her work.

> To be honest, it was mandated. But through the, through the program, I also learned a lot. And it ma-, it made me realize that there's room for improvement. And if we are going to move forward with truth and reconciliation, that's not for somebody else to do that's, that's for all of us to do. And in my role in our school division, there's, there's lots of opportunity to be a leader. And in doing that, you know, making that kind of consideration, because we have a lot of Indigenous families in our school division. And taking that into account and making it relevant, not just a one off, but you know, really having a, an accurate reflection of Canadian history and an understanding of it. And, you know, how do we move forward?
>
> (Lena, initial interview)

The training opened her eyes to the systemic and historic injustices and racism experienced by Indigenous people in Canada and she shared these new learnings during her initial interview, comparing her ancestors' experience as newcomers to Canada with the racism experienced by Indigenous families.

She defined culturally safe practice as:

> I think it comes down to respecting everyone and to not have preconceived ideas of where in the case of, you know, working with families and kids, you know, oh, they're they they're not going to bother following through or, you know, here are some barriers that need to be addressed before we can go anywhere. So, I think, yeah, in a word it would be respecting individuals of any culture and socioeconomic group as well.
>
> (Lena, initial interview)

Her goal for the community of practice was to come with "an openness and a desire to learn because I see and talk to people who I feel are really ignorant in, in their in their view of Indigenous people of First Nations communities, and, you know, there is an opportunity to share a different perspective" (Lena, initial interview).

In the initial interview, Lena shared facts and provided examples from her learning. By the final sharing circle, she was more self-reflective, describing a shift in her perspective:

> This has, it's been a real privilege to be a part of this. And I too have learned a lot from all of you. And I think when I considered just the last four months, I think part of what I feel my purpose is, is to ask questions, and to listen with, with a heart, that desires to understand as opposed to just taking down facts and being objective. And so, not- with

> all my clients, but and I think that focus is for all my clients, not, not any one particular group. And I think that when that is your objective, parents feel that or know that, and it changes the relationship. And even though we have a very limited amount of time, I feel like it's, it's really effective.
>
> (Lena, CoP#6)

Over the course of the community of practice Lena's language shifted in how she described the racial identity of herself and others. In the initial interview, she described families as Caucasian, and did not identify her own race. By session two, she described herself as a "White settler". When asked to describe her positionality in the final interview, she stated "I am an Occupational Therapist here at Rehab Center for Children. I am a first generation Canadian with a family history from Eastern Europe. I am a wife, a mom, a sister and and friend, a neighbor, coach, a colleague." (Lena, final interview). This quote illustrates the learning that Lena had that shifted her perspective on her positionality and unearned privilege during the CoP.

> You know, I'm a first generation Canadian and my parents, we lived below the poverty line, but I never knew it, because they managed to still purchase their own home and look after it, and they worked. And and I didn't know that until much, much later. And so they worked hard. And it's like, well, I worked hard, and I got to where I am, because I worked hard. But then in, in looking at this article, there's certainly opportunities that I was afforded, that other people are not. In looking at this, "positioning myself", the White settler versus Indigenous people, you know, is just striking. You know, it's like,

> well, I worked hard, but it's like, but I had all of these things. As a, just an assumption, you know, something that you take for granted. And so, this little pictograph was a real eye opener of, oh, yes, but the kind of job that I got after high school to pay for university, the fact that I could apply for loans and bursaries and scholarships, you know, were not, it's not a blanket kind of a thing. The, the profession that I chose, going to university being able to go to university, or physical proximity, like all of those sorts of things. It was like, “Oh, yes, I am privileged, it wasn't just hard work that got me here”.
>
> (Lena, CoP#2)

Lena identified how CoP learning changed her approach with Indigenous families. “I think the process has made me more sensitive to Indigenous culture, and I desire to try and understand how, how their history impacts their families today, and have just a bit of a softer touch, not being quite as dismissive” (Lena, final interview). Lena described how the CoP prompted her learning process.

> **Lena**: I think the biggest thing was, like, setting aside this hour and a half, to focus, as opposed to, you know, fleeting. Or, you know, if you're, if you're listening to a lunchtime webinar, or, you know, there's something else distracting you, you know, this was dedicated time and you had questions. I got to think about what I have to think about, what is my stance on this? What do I feel- what are my biases and my stereotypes? And, like really, like articulating them. And you know, the definitions of, you know, microaggression and that sort of thing. It's like, “oh, yeah, that's me”. So I think, like we were forced to think.

Chris: Okay. That intentional time.

Lena: Yeah. And I think hearing other people's perspectives as well. And I mean, the thing, after the first group, it was like, wow, this is a really homogeneous group.

Chris: It really was.

Lena: There's not a lot of diversity here. But people's experience is diverse and and I think just connecting with clinicians who, from other areas that our cross- our paths don't cross otherwise. That that was valuable too.

(Lena, final interview)

Lena found the resources used in the CoP very helpful. With these resources and the support of the group, she connected topics such as intergenerational trauma, and relationship building to the care she provides and was able to identify how this resulted in a shift in her approach to care: listening more deliberately and deeply, with positive outcomes. I had a family that I- it was a screening, but I did a follow up call. And it was a kid with sleep issues and regulation, and. We, we talked a little bit about tell me about you know, bedtime routine and stuff like that. And. And she's- this mom said, “you know, like yeah, there's”-We talked about the room, and there's toys, and there's posters, and I think even probably a TV or something. And I was like “yechh, well, that's not really conducive to sleep”. So we just talked about sleep hygiene. And, you know, having a calmer, slower, darker, quieter, to see if that will make a difference. So I called her like, a couple of weeks later. And she said, “we did what you said, and she goes to bed at eight. And, you know, she sleeps through till the morning.” And, you know, I'm,

> on one hand, I'm going, “of course”. But then she said, “Nobody ever told me or taught me how to do that. But it worked. Like you told me what to do and it worked.” Again, on one hand, of course, but on the other hand, it's like “nobody ever told you.” And, and I think what I've seen is there's a lot of parents, and again, not just Indigenous, but a lot of parents that nobody ever told me. So but particularly with, and maybe in these other cultures as well, or with these other families as well, that extended family, there wasn't there wasn't that parenting of the parents to know what to do that it's not instinctive. And it's not just intuition that you do that. But then I thought, you know what, if nobody ever spent the time or did that with her like nobody- If that wasn't something that your family did, or if you didn't have family to work through that, then, no, you wouldn't know. So and I think, in general, and here too, I struggle because I have I have four appointments to develop a relationship and get trust and say something meaningful and get somebody on board and, and, I know that we're more flexible than that. But when there's those kinds of time constraints, you're always thinking ahead to what do I, what can I provide? What do you need? Instead of taking a moment to pause and listen, not just asking all the questions that we need to ask but leaving time for, you know, “what would you like to add? What do you want to tell me about your family well be helpful to know?”
>
> (Lena, final interview)

Lena’s personal values of service to community, leading by example, and the responsibility to take action are exemplified in her planned actions going forward, which

include volunteering at her community Head Start Program and to work against racism in her personal and professional spheres of influence. She identified anti-racism as an area for future development for herself.

> I appreciated the- well there was lots of resources, but the "Calling people in, Calling people out" -because I think that was something that, there was there was uptake from that. It's like, oh, I would do it if I had a bit of coaching on how to do it without being, without offending someone. And not shutting down dialogue but encouraging.
>
> (Lena, final interview)

Doris' Journey: Broadening My Understanding

Doris is a 55-59 year old woman who described her positionality as

> I'm a White settler woman of Dutch German Mennonite heritage. My family arrived in Manitoba in the 1870s. And I am an urbanite with roots in the farmlands, I am educated. I'm a woman of faith. I am a person who is passionate about learning how to walk alongside others. I love the sun and being outdoors, doing activities powered by my own body, skating, skiing, biking. I'm a person who prefers being with people but lives alone. I have a strong desire to understand people and what motivates them. I come from a family with a strong ethic of helping others in need and sharing what we had. And I could go on, but yeah…. I'm not sure. It is an interesting question. And I think it is something I will continue to work on, think about.
>
> (Doris, final interview)

Doris describes a strong emphasis on service to community as she grew up. Growing up in rural Manitoba, she had some exposure to Indigenous communities, and in her early 20s she volunteered with Mennonite Central Committee in a summer community gardening program which helped her to notice her racial identity.

> But it was kind of my first real immersion, should I say in an Indigenous community. And at that time, I would have known much less about the actual history of, of the Indigenous peoples, and, you know, residential schools and the impact of that, but I just know that my impressions from them or from then was what a lovely community of people. And I don't know if this is appropriate to say, but the weirdest person in the community was a White guy. And and coming out of the community, because they were basically there were not a lot of White people in that community, coming out you know, then all of a sudden, I became aware of, you know, the faces around me were more of a different color. And so just Yeah, I think it's just some of that awareness. And I think, you know, so it's really hard to say because it really for me, I don't know, if there's been any huge kind of, oh, this is, you know, this is my awareness like it, it gradually in as, being exposed to other cultures, you know, spending some time in Brazil, like, five months, and then in Egypt, you know, three and a half years and and even the training that we had as occupational therapists, I remember the emphasis on, on well, knowing your own biases and your own values, but then to be able to understand and or at least try to understand the ethics and values of your clients.
>
> (Doris, final interview)

In her career that has so far spanned more than 20 years, Doris has worked primarily in private practice and contract services in both community and school settings, including work in some Indigenous communities. Doris opened her own private practice in the last year (2023). Her practice includes providing OT services to individual families and schools in rural and urban settings, including school aged occupational therapy in Indigenous communities, and assessments with a northern FASD (fetal alcohol spectrum disorders) assessment team. Doris highlighted the importance of building relationships within the communities in which she works.

> I think, you know, at this point, it's been more really listening maybe to them, they have, I have had people share traumatic stories of their lives with me and to be able to hear that I think does shows a certain amount of trust in me, I think. Yeah, I think that's something I'm gonna have to think about a little bit more. Because I tend to, like if I think of my last visit, you know, I was running from the school to the office, from here to there. I know in in one situation, it was just my own accountability where I was kind of getting a little impatient like, “Okay, if you're, you know, like we need to move on” and like "no, this person is in front of you, even if you can't necessarily do anything about her pain, her situation. She's talking then maybe that's what I offer her is my listening ear". So maybe, yeah, to think about that myself in my listening to the person in front of me instead of focused on the other a hundred things I'm supposed to be doing.
>
> (Doris, final interview)

She also noted the importance of being aware of her own culture and the values she holds, taking care not to project those values onto others. She learned these lessons during her time working in Egypt and in Indigenous communities in Canada as an occupational therapist.

Doris has become more aware of the inequities and trauma experienced by Indigenous People and communities in the last 5 years. She has begun to do independent reading including the Truth and Reconciliation Commission of Canada report among other books and has taken part in education modules required by some Indigenous communities as a condition of her employment in the community. She spoke of the link between Trauma Informed Care and work within Indigenous communities, given the historical trauma most have experienced.

Doris was motivated to join the community of practice to learn together with other OTs in a community. Her goals for the community of practice were to increase her reflexivity regarding individual interactions/ therapy sessions, and being open to address difficult topics within the group.

Her definition of Indigenous Cultural Safety includes awareness of the differences between one's own culture and others one encounters and the need for reflection, triggered by getting to know people from other cultures. She spoke of the strengths in each culture.

Over the period of the community of practice Doris noted personal challenges that prevented her from engaging to the extent she had hoped to. Despite this she attended 5 of the 6 CoP sessions and engaged in the sharing sessions. She noted that the community of practice helped her to notice individual and systemic barriers in her personal and professional life. She

shared her attempts to balance advocacy on behalf of her clients with supporting and affirming their agency.

> Oh, another thought I had here was the need to walk with and not do for. And I think there was a well instance, in my last trip up, I discovered that in questio- in talking to a parent about a child, parent was telling me, you know, the child was having trouble seeing. So I'm like, well, when did they last had their vision tested, right? And so the parents said, Oh, before Christmas, there had been an eye doctor at the school and child had come home saying she needed glasses, but the parent got, the parent had signed permission for the child to be seen, but got nothing back from the eye doctor. And so then I you know, started inquiring. And I found out that yeah, indeed, this eye doctor had been at the school, parents had had to give permission. But he got nothing back. And all of a sudden- and then they got glasses in the mail for their child. Like, with no, not even like a prescription, not even a note, like nothing. I'm like, “really? How can you do that? Just go into the community and?” And, incidentally, so initially, I was, I was- the reason I was walking- talking about walking with. So I think I ended up doing my part by finding the phone number and email and website of the eye doctor, and then I passed it on to the parent. But initially, I was thinking, “oh, we need to, we need to, you know, find out what's going on here and and find out where these glasses are for this child. Like, why does this child not have glasses?” But with with, I will say also some reminders there was like, okay, yeah, well, you know, we'll start with giving this information to the parent. If the parent does need more assistance, you know, it's not like, we can't give it

> but it's bit of a reminder there too that, yeah, not not do everything for them. But it still makes me a little mad with the eye doctor.
>
> (Doris, final interview)

During the community of practice Doris noted several meaningful take-aways: 1. to listen with intention and respect as she builds relationships, taking the time necessary in her practice, 2. to consider how she can be attentive to and acknowledge racism in her personal and work environments, calling people in rather than shaming and pushing them away, and 3. to examine the theories and assessments she uses in her practice, paying attention to their cultural relevance as well as the impact of her own values and beliefs on her practice approaches.

> Well, I guess the one that I think of now is that article about occupational therapy and assessment, and it's one of the things I have been thinking about for a while like, is, are the assessments that are available to me the ones that are using, are they actually useful and relevant and appropriate for the clients that I'm assessing? So yeah, and I don't have an answer for that. It's what I have available right now. And that's what I'm using. But, you know, I sometimes think about...need to develop a new assessment or something. And I think it was also in that same article where I've talked about building relationships and taking more time. So that was one of the things that I, I was reflecting on as something that I wanted to consider in my practice. Am I taking the time to build those relationships? Yeah, so it's kind of some of the reflections I had.
>
> (Doris, CoP#5)

Reflecting on her participation in the community of practice, Doris shared:

> And then you're asked about how participation changed my perspective, and basically, I would say that it has has broadened and deepened my understanding, again. I don't think it like I said, I feel like my journey has, you know, been, you know, kind of gradual, sometimes a little bit, learn a little bit more, a little more quickly. And. And so I think it has helped to just broaden and deepen my understanding and even brought some clarity to my own thinking and my way of practice. Certainly, it's been meaningful to discuss with others. And I find, I think I said in one of the, in one of the sessions that sometimes I come having no idea what I'm going to say,…and then as people talk, then I think of things and so even when I was doing this, I should do this in that group, then I would remember more of, you know, someone would say, Oh, I, you know, I learned this is how it impacted me and me. Oh, yeah. That that worked for me, too.
>
> (Doris, final interview)

She shared that an unexpected part of the CoP was the opportunity to explore her own positionality and purpose while discussing the four great questions of life (Sinclair, 2014).

> And then what I mentioned before, I do want to continue to consider also those questions. Who am I? Where am I going? And what's my purpose? And I would not, I think that would have been maybe the unexpected part of getting, getting out of here. I'm thinking more just about cultural safety with Indigenous people. Not thinking so much about these questions playing into that, maybe. Yeah, I think that would be part that I hadn't, I hadn't expected.

(Doris, final interview)

Moving forward, Doris plans to attend ceremony when invited/ available, continue to build relationships in community to which she can be accountable, "be a little bit bolder" in her response to racism, and develop her own land acknowledgement that is meaningful to her and respectful of the communities she serves.

Susan's Journey: Reaffirming My Commitment to Equity

Susan is a White woman of Ukrainian, Polish, Irish and Scottish background in her mid to late 30s. At thirteen years of age Susan moved from a "very homogenous, like prairie school" (i.e. primarily White population) to a small Northern Manitoba town of approximately 4000 people where she attended junior high and high school. The town is a community in Central Manitoba, with a large Indigenous population located nearby. Here Susan learned about residential school and the social and health inequities experienced by Indigenous people both in school and through the relationships she developed.

> And it was a much different kind of experience there. There was a lot of different, like more socioeconomic status groups, and the kids from the reserves were actually like, bused in and like, from their reserves, and like, would come to our school and be like, boarded, billeted throughout the week so that they could attend, because there was no high school there. So they were coming from like, an hour away….But it was, I think, a lot of just experiences, you know, like meeting some of these kids and learning that their background was much different than mine was, and, you know, that they were going through a lot of things that I wasn't going through, and you know, their academic

> performance was impacted as a result, and their you know, post-secondary options were, as a result, you know, different.
>
> (Susan, initial interview)

As she proceeded into university, Susan continued to explore social justice and equity-oriented topics, considering social services and occupational therapy as career pathways. She notes she did receive some cultural awareness and sensitivity training through her summer employment and occupational therapy training, which helped to highlight the historical experiences of Indigenous communities with health and social services and the challenges with medical model approaches to care.

During the first years after graduating as an occupational therapist, Susan worked in Northern Manitoba in both Indigenous and non-Indigenous communities. Reflecting on her early occupational therapy practice, she notes that she did not have much formal training in providing culturally safer care in Indigenous communities. She received some informal mentorship around working with Indigenous communities, but it was primarily focused on being a new therapist, not new to work with Indigenous communities.

> I've done just like some general reading on cultural safety and, you know, reading on when I first moved to *small town in Northern Manitoba* and was and was working with several reserves and different Indigenous groups just kind of learning a little bit more about, you know, their past and things like that, but also as a clinician, like, what is what is appropriate? And I think actually, some of it was maybe informal learning from a mentor as well, because I was kind of, you know, a new grad. So I was like, Alright, I'm

> working on fine motor skills, and, but like they're, this kiddo is, you know, maybe in a different social situation. And, you know, there's other dynamics going on in the home, like, how do I reconcile like this child going through trauma and me wanting to work on something that's maybe not what they need at the moment. So I feel like I had more informal education from mentors as to like how to navigate some of that.
>
> (Susan, initial interview)

She proceeded with her work, based on her own personal experiences and good intentions, but little organizational or structural support. In retrospect she acknowledges that she

> So there was a few of those situations where, again, I'm like, in some ways, like going on to these reserves schools and meeting the Indigenous clients and the families and working with them. And it was great, but I don't know that I had any formal education on how to be culturally competent, or, like cultural safety. It was more like, I'm familiar and friendly. So and I'm well meaning, so I'm probably doing the right thing, right? ... I would usually go and kind of like, meet with the teachers or the resource teacher, and kind of get a sense of like, what their, what their goals were, or what the family's goals were. And so I think, because I focused on those things that probably saved me from like, probably doing something more harmful, which is like, I think you need to do this. So I think, you know, because it was my first job. And I wasn't the most confident therapist, I didn't I don't think I would, I don't think I caused any harm. And I don't think

> I like put my beliefs on anyone. However, I think that is just by sheer luck that I did not do those things, because I kind of didn't know what I was doing.
>
> (Susan, final interview)

Susan's early attunement to health and social inequities faded with time as the demands of learning her role as a new occupational therapist, subsequent busy caseload, and needs of her young family pulled her attention and focus elsewhere. Susan has now been an occupational therapist for 17 years and has worked in her current role for 5-10 years. She works in Winnipeg with preschool children and their families, as well as in a high-risk newborn follow-up program which follows premature infants at specific time points to track and support their development. Many of the children and families involved with this program are Indigenous.

Susan shared that the term Indigenous cultural safety is newer to her, learning about it through the offering of training in the health region. While she hasn't had the time to attend the regional training yet, she expressed a desire to learn about Indigenous cultural safety and revisit issues of equity including neurodiversity and cultural safety in her OT practice. Susan described her understanding of Indigenous cultural safety as clients feeling "safe and respected" while accessing care (Susan, initial interview). She adds that it is important for healthcare providers to be aware of the history Indigenous people share in Canada and its impact on healthcare interactions.

During her participation in the interviews and the community of practice Susan shared that while she was attuned to her own socioeconomic privileges during university, she had not considered how her positionality may influence her clients perception of her, how her

positionality and power may impact the client relationship. Susan shared that participation in the CoP helped her to reflect on her positionality and power and gave her confidence to explore how to be a culturally safer practitioner in several areas including ethnicity, race, and neurodiversity. She was able to relate it back to current continuing competence requirements from the occupational therapy regulatory college and plan actions for future goals. In relation to anti-racism specifically, Susan noticed her tendency to explain away behaviours that appear racist, giving the benefit of the doubt to the perpetrator. “(I)t just made me think that maybe my tendency is to kind of like, try and rationalize bad behavior. And maybe I'm going to try and pay attention to that in myself this next little bit.” (Susan, CoP Session #3)

Susan valued the time spent in the sharing circle stating what “was most impactful was the sharing” (final interview). She found that the time spent in discussion with group members and reflecting on the readings provided additional opportunity to learn from each other and facilitated reflection on the content. She spoke about the importance of working together towards culturally safer occupational therapy practice and continuing in a group setting, making time to do the work.

She described the impact of participating in the CoP on her practice as bringing the historical context to the forefront of her mind again.

> I think, like, I was just thinking, even just like bringing some of the pieces of like, like, the residential school system, like I knew about it, I did, but bringing it to the forefront again, and like, you know, there's so many families, I see, I was reflecting on that, like, you don't really don't feel comfortable with daycare, don't feel comfortable with

preschool, don't feel comfortable with the public system. And I think sometimes I'd be quick to be like, “but like, daycare is really good for your kid” or like. But I think when we were talking, I was like, you know what, like, there- it would be normal for them to have like a suspicion or like a fear of that system, based on those experiences. And I don't necessarily know that that's why someone doesn't want to- I think several times I've had it come up. But I think, you know, instead of being like, “this is really good for your child,” to reflect on that and be like, what are your concerns about? Or how are you? What, how are you feeling about that? Like, what's made what makes you uncomfortable?” And if they said, like, “I just don't like”, and actually I've had clients say, “I don't want anyone else taking care of my kid”. I think previously, I'd kind of gotten out of the picture of thinking of it from like, an kind of a historical, like, an Indigenous cultural piece of it…. I just got outside that's kind of recognizing some of those themes and being more- so I think this was helpful to kind of help me kind of just reframe some of those pieces, because you do see things like that. And then I think in especially in the first couple groups, there was just some more discus- I mean, yes, discussion about privilege, so being more aware of, of that piece. As well as racism, and I think like just being more aware of like, overtly racist things that happen in the workplace, like whether it's, me- might not even be in your session, but like, what other people are seeing at work and in life, and I feel like this was good at reframing things for me to be like, more of an advocate in my daily life, I feel like.

(Susan, final interview)

Susan spoke about her own tendency to rationalize behaviour rather than addressing it head on. During the community of practice, she committed to noticing and responding differently, re-engaging in her practice with an equity-oriented lens. Going forward she has committed to building relationships with families, understanding their needs and using a strengths-based approach to engage in OT that is meaningful to them.

Katrine's Journey: Discovering My Own Power

Katrine is a White, cis-gender woman of Prussian/Russian, Mennonite ancestry in her mid to late 40's. She grew up in a "very White, blue collar community, there wasn't really any diversity at all, of any kind" (Katrine, final interview) and when her White race was identified during overseas travels, she felt "othered" and singled out, but did not realize that this attention was related to her relative privilege as a White woman. Moving to Manitoba in her 20's, a year before starting OT school, she saw more Indigenous people, but admits to limited interaction with them and to holding racist thought patterns and beliefs towards the Indigenous people she saw.

> I feel like early in my career the places I was working, the other people I was engaging with, like, yeah, it was learning about what it meant to be an OT and growing in my competence and skills and knowledge in sort of the OT world. But probably at that time, if you were to ask me, I would have said, "Oh, no, I would- I'm not racist. I'm, yes, of course, I create cultural safety". And, and if I think back to who I was, like, in my early 30s, like, "color doesn't matter, I'm married to a Hispanic person, right?" Those would have been the stories that were my truths of that time. It doesn't matter, the color of

> your skin, everyone is wonderful. We're all human, those, some of those things. And so I call it status quo part of my story, because I feel like that was in the like, you know, 20 ish years ago, that that was sort of the mentality of probably the majority of White people.
>
> (Katrine, final interview)

During OT school, Katrine completed a placement in a Northern Manitoba city and was able to visit some Indigenous communities in the surrounding area. She described becoming aware the longstanding presence of the Indigenous people there and her early attempts to create safety and connection through learning some words in Cree.

> I think it was the first time I had really even, which seems weird to say, thought about that there were people in Canada before the settlers, right? Like, is it something in the schooling, like, when I was growing up, people were not talking about First Nations, they weren't talking about Indigenous Peoples of Canada, that wasn't part of our history, like lesson. And so I think I was absorbing a lot. I didn't, I was trying to learn a couple of words in Cree so that I could greet people, and wanting to be respectful without knowing a lot about a culture. But I do remember, like, thinking about, like, wow, I really, I don't know a lot.
>
> (Katrine, initial interview)

> But I learned in the communities I was, people were predominately speaking Cree and so I learned some basic Cree language but that was really the end of what I thought was being culturally safe at that time. Oh, look at me right and like feeling probably a sense

> of like pride of like, I'm doing this right. Oh yeah, it's sort of embarrassing to actually like name that I can imagine like 28 year old me thinking like, oh, yeah, I got this. I'm so making people feel safe and welcome and seen.
>
> (Katrine, final interview)

Katrine has been an occupational therapist for 10-20 years, and now has her own private practice. Her motivation to learn more about Indigenous cultural safety was triggered by the Truth and Reconciliation Commission of Canada report and Calls to Action. Over the last 5-6 years, she began to reflect more intentionally on her positionality and impact on others, seeking out opportunities to learn more about Indigenous cultural safety, including historical context and current equity issues. She considered her own family history and its impact on the Indigenous people that were already living here when her settler ancestors arrived, recalling an impactful article highlighting the historical inequities experienced by Indigenous People in Canada and their ongoing impacts.

> And the article that sort of has stuck out to me the most was a first-person article, I'm not sure which if it was in CJOT, or where it was published, of someone who would have been a similar age and ancestry to myself. And she talked about how when her ancestors came to Canada, they were given land, they had freedom to vote and all of these rights that Indigenous and First Nations people in Canada did not have at that same time. And her ancestors could come and be abundant and create a life for themselves. At a time when the people who've lived here for generations before us had none of those rights. And I had never thought of it in that those terms before. And I felt

like oh my gosh, how have I never thought of this. But yeah, it's was it's it was not something that anyone really talked about. At least not in the circles where I was. Or, for some reason I wasn't open to it. I really thought a lot at that time of like, how am I never recognize this before, that the discrepancies and that, yeah, just the profoundness of the differential of and that would have been like my mom's grandparents came from Russia in the 1920s. And they and so I've learned a lot about you know, they came and they were gifted land they literally were offered when their boat came, landed, they were offered two plots of land in Ontario, two plots of Metis land in Manitoba, or two plots of the land in Saskatchewan. And so it's really confronting that they were given this land that CP rail was giving them that wasn't CP rails land to give. And I always heard the story from, like grandparents and that, “oh, there was so many hardships of farming at that time.” And it was all like, “the plight from Russia was, you know, it was awful”. And, yes, it was, and the Russ-, and then my dad's parents, they stayed in Russia, well, what's now Ukraine, and, you know, suffered under the hand of the Russian Revolution, and the White Army and all of those things…

Chris: I think we might be related on both sides.

(both laugh)

Katrine: And I always heard the stories of all of the hardships and all of the, you know, the resilience that we had, and that we overcame. And now look, we came to Canada, and we're so prosperous. And I've challenged my dad a number of times over the last year, and just like, “yes, *and* also what is true is,” so then my dad's parents when they

ended up leaving Germany, because then they would have been in Germany after World War Two. Would- Paraguay was one of the only countries taking immigrants and so they were- ended up in Paraguay, given land to settle these villages, that again, I'm like, “okay, but whose land was this? Probably the Guarani, the First Nations peoples in Paraguay.” Yeah, it wasn't really fertile land, but they made something of it. And then they came to Canada, and they farmed land in Canada. And so it's sort of this. So part of my journey has been re-understanding, well, first understanding and then like, trying to put together that complexity of sort of knowing that, you know, I *am* a settler in Canada, and my ancestors were ones that were part, not that they knew differently. But that we were able to prosper. Because we were a settler. That’s, at a time when we now know how many harms the residential schools, the 60 Scoop, like, all those things happened. After all of my ancestors were already living on this land. So it's, so for me, knowing more about the truth of where I came from, and how my relatives came here. Then I can start to and I'm just, I don't even know it. Like, it's just I feel like, again, it's knowing and naming the truth. And it still, and this is, again, this hasn't-not related directly to OT practice. But I feel like

Chris: It's all a part of your story.

Katrine: Yeah. Because who I am and how I show up, and how I see people and how I just perceive the world and how I am in the world. It I don't find it hard to like, there isn't a blind for me of like work KATRINE and I know some people are very boxy that way, I just am who I am in all areas of my life. And so. So, part, a large part of my story

has been understanding my ancestry and journey to be able to place it in the greater context of our country and of other things that were happening. And trying to just, yeah, piece together the “both-and”. And this is what I've also been thinking a lot about is and like, actually, who is naming this publicly and acknowledging this publicly? And how do we move forward? Because, again, there are a lot of settlers that have come to Canada that have experienced a lot of harms. And I remember, Deborah Ducharme? Deborah?

Chris: Deborah Beach Ducharme?

Katrine: … And I know this isn't the first time that it's been said, but she talked about how "hurt people, hurt people, healed people, heal people." And, you know, I've heard a number of Indigenous elders say that. And so it feels like part of my responsibility and journey is to heal and understand some of the hurts and traumas of my own ancestry.

(Katrine, initial interview)

During this period of learning, Katrine considered her role working in Indigenous communities and how her OT practice should change. She chose to pause accepting contracts with Indigenous communities until she had done more individual work including revisiting her positionality and her role in Truth and Reconciliation individually and as an occupational therapist.

(H)ow am I is a settler offering grace and reconciliation and compassion in the way that all of our First Nations peoples are, are showing and offering to the massive harms that we have caused and continue to. And so, yeah, it feels like there's the work. And so I went on, now, I think how I've shifted in my practice, is I didn't realize how judgy I was

previously even without, like, not even consciously recognizing it. But just seeing each person for however they show up in I think I said I did that before, because you know, I want to believe that I did. But I feel like I am able to do that in a more real and authentic way, now, and just in and hearing, hearing stories with more openness, and not adding as much as my bias, just hearing the story for what it is with more grace and compassion. And it's something that I think can only happen when you also can sort of acknowledge some of your own... (pause) I don't know. Like, not demons necessarily, but your own biases and your own truth and not, not covering them up. But just it is something, we can't change the past but we can also but we can in that we can- the way we tell stories, the way we talk about things we can also go back and say "actually, yes, this happened, and now we know differently." And we can say "I'm sorry for these things" and we can name the specific things as a way of moving forward. So I was intentionally, for and then I also did some work in mentoring and supporting some of the new grads in the Manitoba First Nations Education Resource Center. So, visit- travelled to a number of First Nations communities alongside many of the OTs that were working in that organization. But it wasn't until I had one of the new grads was someone who identified as Indigenous, that I realized how White settler I was approaching the supervision and the mentorship, and I actually, I, I act- after that year, I stepped back from that role, because I said, I don't think it's right for me to just come in, as an outsider, who's not actually part of this organization, and offer that support. In this way, it feels very White settler driven, power differential, like, there needs to be relationship

> and that's, you know, and so that's how I kinda- I, it, but, it was very, like,... a lot of it's confronting is, you know, we always hope, and try to do, and we are doing the best we can, but we can, need to do better.
>
> (Katrine, initial interview)

Katrine was the first person to sign up for the CoP. She registered within a day of the invitation being shared with private practice occupational therapists. Katrine's goals for the CoP were to learn how others create safety within her own OT practice and to explicitly state how she plans to create safety within her practice.

Her definition of ICS included the individual's perspective on their own safety, and for them to be able to express themselves without fear of judgement. She added that the occupational therapist must exhibit cultural humility, because awareness of the culture of someone else is limited by exposure, but when a person proceeds with humility, then they can be open to learning from their client about what is important to them.

Participation in the community of practice helped her to expand her understanding of cultural safety and creating safer spaces in her own practice and by extension in her personal interactions.

> Over the last six months, I feel like every time we met and gathered together and had conversation, there was something a new layer to sort of, for me to consider, to show up differently. And it feels like in a lot of ways, because it there's so much introspection and inner work, but creates outer safety, it's sometimes it's harder to maybe name some some of the impacts, at least for me, because I feel like it's a lot about like,

> creating culturally, cultural safety is about the space you create, by the presence that you bring, and the openness that you bring. And that's a feeling that people get of if they feel safe or not.
>
> (Katrine, final interview)

> And I do feel very much like, you can't just know it and be culturally safe in your professional world and not your professional or personal life. Because then I don't feel like you actually are being a culturally safe clinician if you're only doing it in your professional world. Because it is about creating safety, for humanity, safety in our world, and to shift some of the really big perpetuating beliefs and systemic patterns. If we know it to be true, then we need to live it in all parts of our life.
>
> (Katrine, final interview)

As the community of practice progressed Katrine described the desire and need for continual growth and learning on her journey towards culturally safer care, never complete but always growing. She identified the importance of understanding her own background and her own story on her journey towards becoming a culturally safer occupational therapist. She also described learning “to show up differently”, “listen differently” so clients can “share all of who they are”, emphasizing the need to hear her client’s stories with an “openness to receive as it is intended to be heard and received” (Katrine, final interview).

Part of Katrine’s experience of the community of practice was coming to understand the extent of the power she holds within society. She shared that she had previously felt like her voice as a woman was not valued and that while she held unearned privilege in society because

of her race, she did not hold much power. During the course of the CoP she came to understand her own power in society.

> And one of the probably biggest, there's been a few big lessons, I think, for me through this community of practice. And one has been that shift for me of, I really felt like as a woman, for my whole life that was like that was like, not that it was a hardship, but that it didn't, my voice did it really matter. And I was not ever safe out in public. Some of those stories really, both from experiences that I had. And those were really much more locked in than I realized. And a fear of speaking up and a fear of being seen, and a fear of being visible. And so that activity of the positionality of the circle was really powerful. And in thinking about, I know, in the one group I shared about how like, the city I lived in was the city where Kristen French and Leslie Mahaffey lived and were killed and murdered when I was in junior high, and the impact that had on me, and how our entire community like the entire, like 1000s to hundreds of 1000s of people in the entire really across the country were invested in finding these girls. And…And we were at such an influential age of like, because they were our age, at that time, just a little older for me. And the fact that like, a whole country rallied to find these girls and to seek justice. And that's still, how many years later, 30 years later, isn't happening for Indigenous women and girls and two spirited people. Still, like, and so that was a really helpful reframe, because I saw really, for the first time like, “Oh, I'm actually not the victim here. I have more power and privilege, actually, than I've allowed myself to see”.
>
> (Katrine, final interview)

She then began to consider how she could use that power responsibly- to walk alongside her Indigenous clients, working towards change in herself and the systems around her, personally and professionally.

> But that, I think has been a new era of -is not speaking up, is not an option. And except that when there's someone there who can use their voice, giving the space for them to use their voice, but if someone isn't there to be a voice, and just last week, I was speaking with a resource teacher and she said to me, “Oh, you're only gonna want to call the mom, because the dad is like, gets really defensive. And, you know, you don't want to talk to him.” And I just said, "I wonder what kind of educational experience he might have had. That's maybe triggering for him?" And she was like, “Oh, yeah, I think, you know, it's probably it's probably pretty similar to his child. And, you know, I think he was probably not treated well in school." And so, instead of, it felt really important to me, that we instead of perpetuating these stories, is when people share these judgments, I feel like I also, I have a responsibility to speak up and support others to also start viewing people differently, and not perpetuate those stories. Because it's really heartbreaking how blamed and shamed Indigenous people get from our education system, still. And, and so, it feels like, through the conversations that we've had, and the dialogues and some of the readings, to really, like, call people in like, it really, that felt like a calling in, because it wasn't calling her out for anything, but just an invitation to view it differently. And maybe think about that parent differently and speak about that parent differently in the future, and the other parents. She encounters, right. And so

> that's where it feels like the responsibility, like I feel now. Not saying something is being-perpetuating the racism that is happening. And that doesn't create safety. So by speaking up, that will hopefully have these ripple effects of not just creating more safety in my personal interactions with people, but in broader scope interactions.
>
> (Katrine final interview)

Katrine has noticed small changes in her practice, listening differently and holding space, sharing power and working to challenge systems to change.

> Because, yeah, and another mom too, actually, now that I think about it. But this was more at a daycare, she was feeling pressured by the system to get her child into kindergarten. But she's trying to finish her high school. And if she can work hard, she'll get it done this summer. But the school said, well, she's kindergarten age, if you don't send her now the next year, she'll be in grade one. And the mom really didn't want that. And she's not really ready. And I just reassured Mom, there's going to be options, no matter what you need to do what's right for you and what's right for your daughter. And she was like, "Ah, thank you for saying that!" because she was feeling so, I think pressure slash bullied into doing something that wasn't right. And she didn't have capacity for or time. Like, because if this child changed to kindergarten now, I mean, there would be two months of meltdowns at home every night. She'd never get it, you know, like, there's so many other things. Yeah, and then it just makes me angry about our system. How, despite how much I'm gonna fight for this child's go into kindergarten next year, and how that's the best place, for everyone. How the school system probably

so won't let it happen…..So and the reason I think I say it is because I'm not sure I would have approached the situation, necessarily the same before, but I really heard through the mom, like she just needed support and to be heard. And she wasn't getting that anywhere else. And that's, that's also really unfortunate.

Chris-So being that one who hears her story,

Katrine-yeah.

Chris- Listening differently. There's a reason I wrote it down when you said it.

Katrine- And for her to listen differently, because she was listening to the school, right and for, to, for me, it's like, for people to be able to come back and listen to their own inner knowing and inner authority. Like, she's still the mom of this child. She knows what she needs. She knows what her child needs. And yet, she still was feeling "oh, but I really need to do this now. I'm feeling bad, because I'm not doing this." And so maybe part of it is also like, giving power back. Right? Like, that's like, "No, you have the choice, you choose what's right". Instead of "this is what you have to do." And this is why and I think that's, again, in the system, that's -who's gonna change these (suppressed curse)?

(Katrine, final interview)

Moving forward Katrine indicated a desire to continue learning in a group setting such as a community of practice. She described the need for lifelong learning and reflection- the journey is not over.

Yeah and the- did I say is there any the bits of ceremony and the sharing by Robben and then just participating in the ceremony with elder Helen and elder Mary, smudging and

> just hearing their teachings. Yeah, that's something that I think the experiential- right like there's something about reading, listening, learning, but then you need to really experience and I feel like I might like, have just like dipped my toe in into that. And I think that's where my story will be moving more into next and it was at another, I don't know, I keep drawing a circle which you can't see obviously in in the recording, but it feels like it's all this like it just because it doesn't feel like a forward like line path like it does just feel like listening, learning, evolving. It all is and maybe inside of me, that's how it feels, right, is it's all integrating and coming together.
>
> (Katrine final interview)

She would also like to attend ceremony when invited, share the truth of truth and reconciliation, and update the land acknowledgment on her website to include names of Indigenous communities in their own languages. She expressed an intention to act on her responsibility to speak up against incidents of racism and work to disrupt systemic racism, leveraging the power she now realizes she holds in ways to support and uplift both Indigenous clients and community members.

> And I'm a different person for having been part of this community of practice. And, like I said, not all of them are tangible, external ways. But mindset, beliefs, stories that have shifted, to create that space to listen differently and to receive differently, I think that's, like, we can hear words. But when we listen from our heart with that openness to receive, as it is intended to be heard and received, it feels like that's where I continually grow and expand. And that's been part of- through hearing more stories and expanding

> my understanding. I can continually grow and I'm, I will continue to grow because there is no end point in learning about people or in learning about, and new stories shift and as people's own stories and understanding of their story shifts you, you know, it's just this beautiful thing that I think, at this time and stage in the world, we are in of dismantling these systems that have kept us stuck and boxed in and created so much harm and trauma. Those walls and systems and boxes have been breaking for years now. And they need to.
>
> (Katrine, final interview)

Rachel's Journey: Finding My Role

Rachel is a "White, middle-aged, heterosexual, able-bodied female" (final interview). She is a first generation Canadian whose parents immigrated to a small town in rural Manitoba, where she felt like an outsider. She describes growing up in a family that lived below the poverty line. She paid for her own university education and notes the disparity between her childhood and the current socioeconomic status of her own nuclear family. She values education and continual learning in all aspects of her life.

During Rachel's occupational therapy education, she completed a placement in New Zealand, where she noticed the integration of Indigenous worldviews into the health system. Rachel reports that her experience living in New Zealand and exposure to the health system and cultural safety approaches there has influenced her practice with Indigenous clients in Canada.

> So really interesting, and one of my big takeaways and one of my favourite models I learned when I was there, and, and I really feel like it- I also find within the- in New Zealand, their, the cultural awareness and safety is much higher level than ours is at, at the time anyways. And so that model of practice was common within the medical system, whereas I wouldn't necessarily say that's aligned here. So, I loved that, that that was the foundation. And it was just, that's what they used. But the whole model was based on the idea of *whānau*, which is family. And so, it was a model, it was a house model. And the model was built around, like, you need a foundation, walls before you have a roof. And each part of family and spirituality and the different cultural elements were, built that model. And was within that you looked at the whole person, not just, so it was very comprehensive in that way, compared to like a medical model. But that was the model that they used. And I was, so I thought that was really cool. And just something that wasn't as done here. And so I really appreciate that. And it also, because that was the population similar to in Canada, that often, you know, in certain areas was higher levels of Indigenous populations that we were working with, right, so it was, but they were working *with* them in a different way than we do. …. So that was, that was a big takeaway, and it worked really well. And that model worked really well. And that system worked *way* better than our system.
>
> (Rachel, initial interview)

She has worked as an occupational therapist for 10-20 years. During this time she has worked in both public and private domains, primarily with pediatric clients and their families.

She continues to integrate a wholistic, curiosity driven, family centered approach to her practice.

> I guess I always keep that, that model that I learned in New Zealand, really in the back of my head and ask a lot of questions around, like, the whole person, not just, you know, not just why they're seeing me, and what are the, what's the need of the referral, right? But really keeping in mind, you know, the whole cultural aspect. So, whether or not it's, you know, looking at who they identify as family members, what does that look like? What is the, you know, who lives in the home with them, but kind of culturally what is what is the roles and expectations of, of the child? And what is the, you know, so kind of looking at it from a much bigger picture and keeping in mind, the different you know, a lot of, I work with a lot of families from a variety of cultural backgrounds, and there is different roles and expectations for the children than what I was maybe raised with, right? So it's kind of just asking those questions and being really open about and being curious and having that be like, please educate me on your needs. I don't know what's best for you, you know, what's best and let's figure out a way to to guide, that to shape that together.
>
> (Rachel, initial interview)

Rachel's journey towards culturally safer occupational therapy began when she worked at a large tertiary care hospital in Winnipeg. She took cultural awareness training offered within the health region, but found it focused on awareness of cultural differences rather than creating safer experiences for clients. She has attempted to access the Manitoba Indigenous

Cultural Safety Training, but has not yet succeeded in securing a spot, so instead she had done personal reading, attending advertised lectures and listened to podcasts to develop her own knowledge.

Rachel has worked in her current role as a private practice clinician for 5-10 years, working primarily in mental health, trauma and attachment with children and their families. She describes a strong commitment to building relationships and uses strengths-based, trauma informed approaches in her practice. She describes her approach to occupational therapy as coming from a place of curiosity and seeking to understand the needs and goals of her clients. Rachel described cultural safety as:

> (E)ducation and awareness around cultural values and rituals, norms within a culture that are important to the individuals who identify with that culture. So providing that or being aware of it and knowledgeable of it of how it is important, so that how does that engage with my practice and how it is what I offer, as suggestions, engage with their culture?, So making sure that what I'm offering is safe in regards to them and their needs. But also, if there's something I'm suggesting that maybe isn't, I don't know if "safe" is the right word but wouldn't align with that culture and therefore might not make it a safe offering of therapeutic choice.
>
> (Rachel, initial interview)

Rachel's goals for the community of practice were to ensure she is practicing in a culturally safe way. She would like to show that she is working towards implementing the TRC Calls to Action. Her desire to learn and understand was a theme throughout the CoP.

> Just that I'm always very keen to learn and always know that this is not a one and done, this is an ongoing journey, and just really want to be doing my part to, you know, to be an ally, and to be providing cultural safe care, and to be a space that people come to feel, feel that and that that's been decided by others, not just by me, right. So it's, I'm not saying "I'm this," it's others that are saying that, right. So it's a felt experience for those who come in into the space. So yeah, it's a very much a no, oh, I have an awareness of wanting to make sure that I'm providing the best care possible. And knowing that this is an area that is one that I don't have as much knowledge on that I'd like to have, and so keen to obtain it.
>
> (Rachel, Initial interview)

Rachel shared that while she appreciated having guest speakers in the community of practice, she also needed the time with just group members to ask questions. She worried that asking clarifying questions of guests may be seen as inappropriate.

> So, I need just more exposure to understand am I, you know, am I not doing something that's culturally safe? Am I missing out on something, because I'm not even aware of it? Right. So, I think it's more than anything, it's led me to wanting more and more learning more exposure. And I think more of those personal interactions. I, every time, I would walk away with more questions. And so, then I'd be like, "Well, who do I ask these questions to? Who? Who can I have this dialogue with without, you know, being afraid to ask the questions because I don't want to come across as insensitive or ignorant or whatever filler word you want to put in?" But I definitely enjoyed our groups, where we

> could maybe have some of those more vulnerable times, those questions and answers and feel like I could ask those questions and be heard, but and not yeah not be deemed in a negative by asking the questions, if that makes sense.
>
> (Rachel, final interview)

Rachel expressed challenges letting go of the Western concept of a single truth when learning from different Indigenous teachers who express different protocols or teachings through story, and being unsure of how to seek clarification in a respectful way.

> So, I guess the difference when I now hear of you know, people- I understand religion is really important for a lot of people in it because I have that foundation, I can hear, and I can listen, I can respect, and I can work with. So. So if these stories that I'm being taught or educated on, are in that kind of also realm of this is something, a belief. I'm not- I think that I'm not sure what my role is and how to work with it. I don't know if that's the right word, but. You know, and is it a, is it a story? Is it you know, kind of like a fairy tale like it's a-or is it- "No, this actually is literal"? Like how much is? Do I mean with that? And so that's where I'm kind of like, like, do you literally mean that? Is it figuratively? Is it a story and it's just a story? So I think that's where I get lost.
>
> (Rachel, final interview)

Her desire to be respectful and not cause harm or offence, prevented her from digging deeper into some of those conversations.

> I definitely had a lot of questions when some of the Elders or guests were there, but I didn't feel that I- not should ask the question, definitely, I'm sure it would have been

received. I wasn't sure *how* to ask the question, with it not being read as disrespectful or ignorant, or- You know, there was definitely things I've learned in the past that things they were saying are different. So then, who do you, whose answer do you- not believe, but, there were varying differences. Right? So and I guess the bigger question, then, you know, I don't necessarily believe everything that anybody tells me so. You know, is that a different thing? Because an elder says it it's, is it necessarily, you know, I listen to and take it in. But is there? What's the protocol? On asking questions when you're like, well, this person said this, and I'm trying to just educate myself, but I don't want to come across as not believing. So that was something I struggled with. Right? And I still do, because I have lots of questions. And like I said, I wouldn't necessarily believe you know, I like to understand where people are coming from and on what basis are they sharing this information, and I want all that information. So that's just how my brain works. And, you know, having the clinical aspect of it, I'm like, interested, but tell me more or this person said the exact opposite, like which one is the truth and it's *their* truth, but then what, which, how do I follow as a White settler and not step on toes?

(Rachel, final interview)

But she acknowledges this is her own challenge to work through.

I think there's, there's parts that I feel like are lacking clarity. And I know, it's my clarity, and it's not the person providing it, this is a me thing, not a them thing. But there's so many, you know, there's- not all Indigenous people are the same."

(Rachel, final interview)

This theme of looking for the right way to learn carries over into trying to find her way as an ally to Indigenous communities. She feels conflicted between her desire to help and her desire to not cause harm if/when she makes a mistake. She has many questions but worries about saying or doing something that may unintentionally cause harm or offend, and so sometimes, hesitates to engage. She gives an example of a time her presence was questioned while volunteering with an Indigenous organization.

> I realized I'm kind of stuck on this, because I've been in a situation where I was called out for maybe not- shouldn't be where I was, and I was there to be, I was volunteering at the Tipi, like close to Thunderbird House. And I was just there working, volunteering for a morning with the Bear Clan. And you know, so the people coming into the Tipi, were individ- individuals who were, just needed the warm space, and there was food and shelter, right? And then I noticed the interactions of, you know, “where are you from?”, and then going back, and that was, it was amazing to hear the stories and that and then one point, you know, one individual star-, the conversation looked at me and said, "Why are you here?" And then I just said, “I'm just here to offer some assistance, you know, provide some food and some water and just, you know, somebody to talk to you”, but it was not okay, that I was there. So, which was fine. But, you know, it's kind of like, how do we show up in, in those roles of trying to support, or wanting to support, and wanting to be present, and wanting to engage, and do those things that are, that are hard at times, but then being- what is the respectful answer in that? And that would

> have been just that one person's opinion, but, fair, and why am I there?....How to navigate that?....
>
> I feel like I can be comfortable being uncomfortable. On my end, I don't want to be the cause of somebody else being uncomfortable. I can sit in my discomfort; I don't want to be a trigger. And that's the, those are a different line, right? And that's the piece that I, just because I'm having feelings, and I can sit with that. But I, if I'm creating discomfort for the larger group of others, or maybe not the larger group, but even one other person who's choosing this as safe space, I don't think that's fair.
>
> (Rachel, final Interview)

Rachel shows a confidence in her clinical expertise and describes how she builds relationships and shares power within her practice but is less confident when it comes to addressing issues such as racism outside of her clinical practice. She set this as a goal for herself:

> I think, what I hope are my takeaway, and what I will try to do also is along that line- but have more the confidence to just, even if it doesn't come out right, to still say something. To not just have a narrative in my head for about five hours after, five days, five days. In the moment!
>
> (Rachel, CoP#3)

Rachel describes her journey as one that will continue beyond the community of practice with ongoing learning needs, and new discoveries of learning needs as she learns more.

> So, I think the journey and being part of the practice and reading the articles and getting to meet the various guests that you brought in and hearing their stories, has just increased, you know, my curiosity and really identifying that there's so much more that I need to learn.
>
> (Rachel, final Interview)

Her journey will continue both in her professional life but also if her personal life, finding courage to take risk, ask questions and learn from those that are willing to share with her.

> So, continued reading, and podcasts and any opportunities for actual events. Kind of all of the above, you know, this is just the beginning. And will be wanting to continuously and ongoing engagement, right, this is, I live in, work in Manitoba. And this is the population that lives in Manitoba. And so, I want to make sure that I am a) doing my part, but also, like, walking the walk that I am saying I am.
>
> (Rachel, final Interview)

> I'm going on a longer path of learning and understanding. Because I still have so much more to learn, and still have more questions than answers. And I found that when I- the motto when I did my master's is that I don't know what I don't know. And so there's still lots of things to learn. Right? And that makes me excited for continuing on and, like understanding and filling up that gap that I know is there but don't know that I don't know, right. So that's definitely the "where I'm going" piece. And I think for what my purpose is, is that I would like it to be that I can set an example within my practice,

> within the clients that I work with, within families, but also within my own family and to my own children. And so that I set, it's just in my in all aspects of my life, that I just have this willingness to learn and willingness to be vulnerable. And sitting with that piece that I really like the, from the article about education as the key to reconciliation, and having that piece of when I can choose to educate those in my practice, and what that looks like and how it's received I think is a piece that I have that ability to do. And also just the- around the really thinking and sitting in the cultural humility and knowing that it's being competent and being vulnerable and being willing to ask the questions even when it's uncomfortable.
>
> (Rachel, CoP #6)

Rachel holds hope that as she is learning, so is the younger generation. She plans to encourage that learning within her own family, creating space for change within herself and with each subsequent generation.

> I'd like to (long pause) Yeah, I think again, maybe it's the separation of clinically versus personally, be more where putting that- sharing, I guess, sharing what I learned in the group, to a degree but at home like with, with our kids and having conversations, again, more on that personal level, than on a professional level, and again, being happy and I guess at times proud to hear their answers and their knowledge and I'm thinking like, "Oh, great". Like they're getting like some of the stuff I'm talking about. They're like, "yeah, we learned that last year", like, awesome, you know, but also they're, yeah, hopefully that this generation or the younger generations will just have more

> compassion and empathy and awareness that is brought in, like they're raised with it in the school system and at home environments. But that was different than our how we were exposed, especially in school. But yeah, I think making sure that when I see things, you know, calling in and having that those difficult conversations, again, more in that personal world, because knowing that there's these younger generations watching me do that, and having been modeling that for them and seeing then them do it after, because they recognize is the right thing to do. And it's important to do, and it's also a safe thing to do. Right? So I think that's something that is more- I think there I've had maybe more comfort doing that. Again, more on the personal level than on the professional.
>
> (Rachel, final interview)

Themes of Participants' Journeys Towards Culturally Safer Care

The findings aligned with the three domains of the Cultural Safety Framework (Practicing Reflexivity, Prioritizing Relationship, and Considering the Context) with one exception. The Cultural Safety framework proposes that a client-healthcare provider interaction is what starts a clinician on their learning journey to be culturally safer clinicians. However, the participants in the CoP described the catalyst as being more broadly about Becoming Unsettled. This title is derived from the work of Dr. Paulette Regan, *Unsettling the Settler Within: Indian Residential Schools, Truth Telling, and Reconciliation in Canada. (2010).* Regan describes the importance of acknowledging the harms of colonization as a catalyst to

move towards actions that work towards reconciliation and healing between people and nations (2010).

Themes in the other three domains describe how participants explored their own positionality, power, and privilege before moving on to exploring how these impacted their engagement with Indigenous clients and communities. Table 7 provides a summary of the themes found in each domain of the cultural safety framework. Katrine pulls several of the themes together in this quote:

> And then it was like, learning how to piece some of those things together. And it feels like every time I've heard someone else speak, read a different book, heard a new perspective, and able to listen a little bit differently and hear the stories a little bit differently. Because now, there's this place where they can go and it just expands my knowing and understanding. And so I think that sort of where it's sort of I'm in this like, ongoing cycle maybe or process of like, listening, learning, knowing and understanding. Because it feels like there's more depth, and like yeah, really feeling the stories. And so maybe that's part of it, too. because they can hear them differently, and understand them differently. And so part of the process for me and part of my story towards creating more cultural safety is really about, I think broadening my understanding, and being curious about each person's story in a new way, that it's not one story. There's many stories.
>
> (Katrine, final interview)

Table 4

Summary of Themes

Theme	Description
Becoming unsettled	This is the beginning of the journey. A single event or multiple cumulative experiences trigger reflexivity and act as an impetus to engage in further learning, acting to ease their discomfort.
Practicing Reflexivity	
Understanding positionality	Examining positionality and changing perspectives on one's own race, ethnicity, social location and power
"Discovering my power"	Exploring the impact of power/ positionality and acknowledging the power and privileges held within intersecting identities. Learning when and how to leverage that power.
Uncovering our own biases	Admitting to and examine the biases held. Group created a safe place to acknowledge biases, sit with discomfort.
Focusing on Relationship	
"Listening differently"	Having reflected on positionality and biases, choosing to listen with openness and understanding, taking the time required to build relationship.
Group support "Broadening my understanding"	Appreciation of group learning environment, pushed to engage actively, stretch and learn together, willingness to be challenged in a "safe space" before trying in "real world" (e.g. anti-racism tools)
Modeling Accountability	Skilled facilitation was key to model relationship and accountability within the group. Participants learned/ observed/ experienced how to call people in, in a good way.
Considering the Context	
Courage to act and courage to make mistakes "Finding my role"	Pushing beyond discomfort to act differently. Courage to examine processes and approaches, assessments etc. for their value and relevance. Acknowledging the importance of trying, even though mistakes are inevitable.
Learning from Indigenous teachers, "Broadening my understanding"	Valuing personal connection and stories and impact on deeper self-reflection. Personal connections made learning more meaningful. Appreciation of teachers modeling connection to land.
Invitation to community and ceremony	Appreciation for the invitation to, and teachings around ceremony. Valuing the worldview shared through the Four Questions (Sinclair, 2014)

Becoming Unsettled

Most participants described a catalyst that brought their attention to the importance of Indigenous health equity and/or the need for culturally safer occupational therapy practice for Indigenous families. For some it was a specific event such as witnessing racism within healthcare or hearing about the impact of residential schools, and for others it was a more gradual building of awareness. These participants described experiences or moments that drew their attention and moved them to start a learning journey. For some participants this catalyst was an identifiable moment and for others, a more gradual pull towards understanding. Doris and Lena described specific moments in time. Lena participated in a mandatory educational program, while Doris was moved by events shared on the national stage.

> To be honest, it was mandated. But through the, through the program, I also learned a lot. And, it ma-, it made me realize that there's room for improvement. And if we are going to move forward with truth and reconciliation, that's not for somebody else to do that's, that's for all of us to do. And in my role in our school division, there's, there's lots of opportunity to be a leader.
>
> (Lena, final interview)

> And it was at the, at the time when Stephen Harper apologized for, because we watched that apology on TV, then when we were there, and it just kind of all tied together. So I think that's really when I became more aware, should I say of the wrongs that have been done to the Indigenous people is probably through that.

(Doris, initial interview)

Other participants described a gradual process of increasing awareness through personal interactions and experiences.

> And I guess then my next part of my story was really learning. And I don't actually recall the impetus of what spurred me to want to learn more and dive deeper. I just remember doing the online course through the University of Alberta, and I don't even remember how I found out about it. And I wish I could go back and actually, like, come back to what was that? Yeah, something likely in my external world had shifted. And it was like, oh, I need to, I need to and want to learn more about this. Maybe it was even my kids being in school. Yeah, I don't remember.

(Katrine, final interview)

Several participants, including myself, also noted ongoing moments of becoming unsettled. Noticing our own or others' racism was a catalyst to reflect about our own biases and prejudices and to revisit concepts of anti-racist practices. I shared an experience of being "called-in" on my description of a foster family as moment of becoming unsettled:

> And she's like, "you could have said, non-Indigenous foster families." And I was like, "Absolutely. 100% Thank you for calling me out". Because, like, it's hard to be called out. And like, I get emotional thinking, like I, you just, I feel guilty, right. And so, then that emotion piece comes out. But I also want to be called out, and I want to like reframe, and I 100%, right away knew "Oh, yeah, I should have." It's, it's not what race that family is. It's that they're [the Indigenous children] being taken away from their own culture,

> and from their own family. And all of the issues around being much more likely to be removed from their family. Like that totally, was not the point. And I didn't need to throw it in there. And it's a comment that I have said before, and I have heard said many times and until that point, it wasn't really called out and I think there are lots of different groups that kind of Yeah,- anyways, I think I think that it's important that that we call each other on that, in the end, like help each other to reflect on why we choose the words we choose and that kind of stuff.
>
> (Chris, CoP Session #3)

While Katrine, shared an instance of noticing her own biases.

> And I was like, "Oh my gosh, like, where did that come from?" Right. Like, and I just like I *(gulp)* realized, right, how some of those biases of "well, this [child having lice] therefore can't equal, you know, any sort of wealth or abundance." So, I really had to check myself and my own biases. In that instance of realizing, yeah, some of the traps that are there that I fall back into.
>
> (Katrine, CoP Session 3)

Several participants described exploring their own discomfort as they considered their own roles in truth and reconciliation and worked through the continued learning that is required of them on their path to improved care and safety for Indigenous children and families with whom they work. Becoming unsettled frequently transitioned into reflexivity regarding one's own thoughts and biases, before moving into a plan for action as Katrine shared:

> What are my actions, because that's where it feels like I need to be. And so I sort of started creating a bit of a, I don't know, manifesto, or I don't know what you want to call it, but just- I'm challenging myself to notice. I'm challenging myself to listen. I'm challenging myself to be open. I'm challenging myself to use my voice. I'm challenge myself to name out loud to others my privilege, power and positionality. I'm challenging myself to be visible. I'm challenging myself to engage in a conversation with others. I'm challenging myself to do better. I am challenging myself to heal. I am challenging myself to challenge others in kind, compassionate and loving ways. I'm challenging myself to challenge the stories and beliefs I hold. I'm challenging myself to be a change maker, an ally and impact social change.
>
> (Katrine, CoP Session #4)

Given this unanticipated finding, a Cultural Safety Framework incorporating the catalyst for learning is shown in Figure 2. This framework incorporates a lightning bolt to symbolize becoming unsettled. The lightning bolt indicates the presence of a catalyst for engagement with Indigenous cultural safety training (ICST). As described above, this unsettling can be a sudden understanding which leads individual to seek out or engage in new learning, or it can be a slow awakening that grows over time. No matter the speed, this unsettling helped participants engage in reflexivity about their own positionality, privileges, and power, and the impacts these have on their relationships with Indigenous clients. Other than the addition of “become unsettled”, the Cultural Safety Framework worked well to theme the participants’ experiences of the CoP.

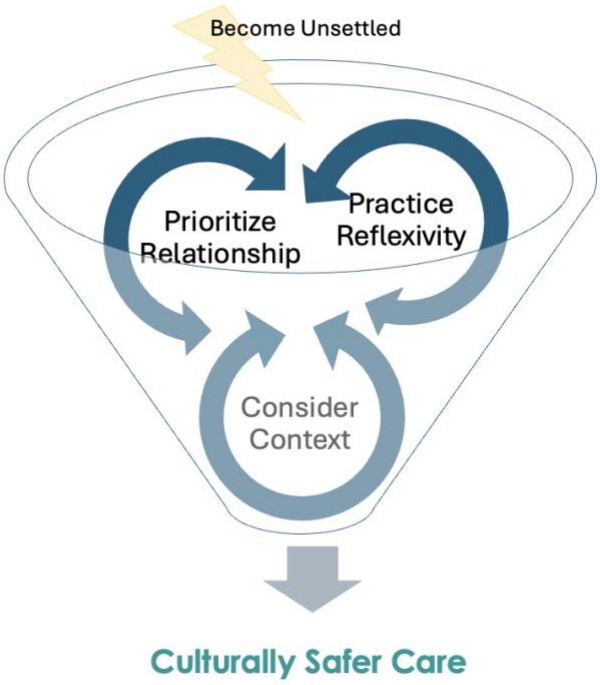

Figure 2: Revisiting the Cultural Safety Framework, Adapted from: Cultural Safety and Trauma- and Violence-Informed Care Framework (Horrill et al., 2021)

Practicing Reflexivity

Practicing Reflexivity is the first domain described in the Cultural Safety Framework. This domain calls on healthcare providers to start with themselves: exploring their own positionality, attitudes, and beliefs and the impact those attitudes and beliefs have on the clients with whom the healthcare providers interact (Horrill et al., 2021). Participants practiced reflexivity through the activities within the CoP: exploring positionality and social location, considering the power dynamics within their relationships with the children and family with whom they work, and reflecting on the biases they hold and how they address them. Within the sessions and during the interviews, participants shared their experiences practicing reflexivity and insights they

gained. Their previous experiences with concepts of social location and power, and their own reflexive processes influenced how they engaged with these concepts. Several facets of practicing reflexivity emerged from participants stories including: (1) understanding our own positionality, (2) discovering our power and privileges, and (3) uncovering our biases.

Understanding positionality

The CoP provided an opportunity for participants to reflect on their social locations and positionality. During the CoP, Grandmother Helen Robinson-Settee introduced the importance of locating oneself in Indigenous communities, identifying connection to not only family, but also community and place. The other guest speakers, Knowledge Keeper Mary Wilson and Sundance Chief Robben Constant, reinforced this teaching as they introduced themselves and shared their own stories. As a group, with Grandmother Helen's leadership, we practiced reflecting on and sharing who we are and where we come from. While participants started the CoP with varying experiences and understanding of their social locations and positionality, this exercise of personal reflection supported several participants to consider how to express their own family history, ethnicity and race differently and the impact these social locations have on their interactions with clients and families. For example:

Some participants' descriptions of their own positionality and connection to place expanded from the initial interviews over the course of the community of practice. Doris and Lena both shared more information about their own social location as the CoP progressed, sharing their race (both White) and family's immigration to Canada as they described their own social location. Along with this expanded description of social location came acknowledgement

of the privileges that accompany the White settler identity. Doris began to describe her experience of White privilege while working in another country, and being in the minority, yet still being granted unearned privileges due to her race. She acknowledged that the discussions in the group of identifying our own race and other components of positionality helped her to recognize those experiences as race related privileges.

Katrine highlighted the importance of acknowledging the truth of the privileges that accompany the White settler identity, sharing that her family benefited from “gifts” of land on arrival to Canada and acknowledge the land was unjustly taken for the benefit of her settler family, at the expense of the Indigenous communities in the area. She noted it can be challenging to acknowledge this truth about her own history but recognized it has helped her to reframe her family’s story and acknowledge the privilege they held at the expense of Indigenous communities.

Reflecting on her own origins and learning of the importance of connection to place in many Indigenous cultures supported Katrine to consider how she might share her social location with her clients as she is making connections and building relationship. She came to realize that connection to place matters to her as well, although she had not previously realized it.

> I don't usually introduce myself with any of my identifiers, or location. But reading this, I know it was based on researchers, but it kind of got me thinking, how do we as therapists locate ourselves with the people that we're working with? And for me, I know, it was brought into my awareness in another group I was in it was a virtual group.

> And when I knew where people were, and who they were, that mattered to me, like, location matters to me, it is what I realized. And that it gives me a sense of like, that's where you are, and that's where you are, and you can kind of visualize and it gives me a way of connecting.
>
> (Katrine, CoP Session #5)

Doris and Katrine shared that using "the great questions of life" as described by Senator Murray Sinclair (2014) to bookend the CoP helped them understand that describing their personal background, positionality, and values may impact their relationships and interactions with Indigenous people and these relationships can be improved when positionality is openly discussed. Doris explained that considering her social location and personal history was an unexpected outcome of the CoP:

> I do want to continue to consider also those questions: Who am I? Where am I going? And what's my purpose? And I would not, I think that would have been maybe the unexpected part of getting, getting out of [the community of practice]. I'm thinking more just about cultural safety with Indigenous people. Not thinking so much about these questions playing in to that, maybe, yeah, I think that would be part that I hadn't, I hadn't expected.
>
> (Doris, final interview)

Discovering my power

After identifying our positionality, participants within the CoP were challenged to reflect on the power they hold as healthcare providers and as White women in society. Katrine

identified that reflecting on her positionality was not new to her, but the exercise identifying the power each of us hold in society was eye opening. Her participation in the CoP gave her a new perspective on the power and privilege that she holds through her intersecting social locations and helped her to reflect on the stark differences between her experiences as a White, professional woman and the experiences of Indigenous people in society.

> And one of the probably biggest, there's been a few big lessons, I think, for me through this community of practice. And one has been that shift for me of, I really felt like as a woman, for my whole life that was like that was like, not that it was a hardship, but that it didn't, my voice did it really matter. And I was not ever safe out in public. Some of those stories really, both from experiences that I had. And those were really much more locked in than I realized. And a fear of speaking up and a fear of being seen, and a fear of being visible. And so that activity of the positionality of the circle was really powerful. And in thinking about, I know, in the one group I shared about how like, the city I lived in was the city where Kristen French and Leslie Mahaffey lived and were killed and murdered when I was in junior high, and the impact that had on me, and how our entire community like the entire, like 1000s to hundreds of 1000s of people in the entire really across the country were invested in finding these girls... And we were at such an influential age of like, because they were our age, at that time, just a little older for me. And the fact that like, a whole country rallied to find these girls and to seek justice. And that's still, how many years later, 30 years later, isn't happening for Indigenous women and girls and two spirited people. Still, like, and so that was a really helpful reframe,

> because I saw really, for the first time like, Oh, I'm actually not the victim here. I have more power and privilege, actually, than I've allowed myself to see.
>
> (Katrine, Final Interview)

Intentionally examining and acknowledging the power they hold in a clear and open way helped some participants to reflect on how they may address issues of power in future interactions and leverage it in ways to support their clients in the future. Susan described how she would like to use her power and influence to improve the care received by racialized clients, Indigenous and non-Indigenous in the healthcare system.

> I mean, I think you could say growth, I think it was things that I like kind of have been part of me, but I put on a backburner mainly just because I had other like, clinical experience to get or I like had other things to work on or. But I think, I think it just kind of helped reframe, like the positive influence that you can have, as somebody in power, not in power, but you know, what I mean, in a privileged position, with like, access to clients that are asking for help, people who are asking your opinion, and kind of the importance of making sure that this is a safe space for all cultures. To be honest, there's a lot of clients that don't, aren't, not Indigenous, but are kind of they're not White, right? They're not Canadian, initially, they're from somewhere else. So I think kind of just recognizing that, like, there's a piece that we can influence here, and there's good we can do by like trying to be as culturally safe as possible. Everybody, yes. And if and if you're not, like recognizing that, like, sometimes we don't say like, sometimes I don't- not say the right things. But I think just kind of like reflecting on it and trying to get

> better, I think is and so I think just kind of like recognizing that. We do have a part in this, like we should, we should do our best whether it's whether it's for kind of being kind of neurodiversity affirming, or culturally sensitive, kind of making sure that as OTs especially with some of the sorry, this is a sidetrack especially with some of the continuing competency stuff we've had lately, right. But just specifically saying like, there's a role there. And like, ethically, what should we be doing? I feel like all of this has been a good way of just really working on that piece. It was timely, yeah.
>
> (Susan, final interview)

One area in which participants expressed new understandings and a shift in thinking was around power within society and with therapeutic relationships. Discussions about power within the context of racialized client-therapist relationship were new for several participants. Acknowledging that power and privilege provides protection and comfort led to questions about how to address power imbalances in a productive way. It also pushed some participants to consider how they may use their power and privilege to advocate for and with Indigenous families.

Uncovering our own biases

A third way that participants practiced reflexivity in the CoP was by identifying and exploring their biases. Some participants shared that they had begun or continued to reflect on the biases and stereotypes they hold, the impact those can have on children and families, where they may have learned them and how they intend to counter them in the future.

The participants in the CoP shared a range of readiness for identifying biases, some noticing biases in others while needing cues to look at their own biases, while other participants were able to identify biases in their own thinking and begin to explore the origins of those biases and strategies to counter them. Lena readily noticed biases and stereotypes held by others in society, noticing them within the school system administrators with whom she works. She accepted feedback from the group facilitator to reflect on biases she holds within her work environment, considering the biases held towards not only Indigenous families but also non-Indigenous racialized caregivers as well.

The biases identified included professional standing (Doris), socioeconomic biases (Katrine), and assumptions about motivations for others' actions (Lena). Within the group discussions, biases continued to creep into conversation and were acknowledged at times and missed at others, highlighting the importance of identified facilitators and accountability. As the researcher, co-facilitator and participant, I benefitted from reading the transcripts after the sessions, and so could retrospectively identify when biases went unchallenged. This highlights the ongoing vigilance required in groups like these, so that biases and stereotypes are not unintentionally perpetuated by not addressing them in the moment. Ogai, a trained, paid facilitator and racialized woman herself, helped us to push ourselves and each other a little further in this area.

Katrine shared moments of catching her own biases while engaging with families and schools. "So I really had to check myself and my own biases. In that instance of realizing, yeah, some of the traps that are there that I fall back into." (Katrine, Session #3)

Focus on Relationship

The second domain in the cultural safety model challenges practitioners to focus on the relationship between the client and the healthcare provider, examining how healthcare providers listen to, and engage with clients to share power and collaborate to achieve the client's goals using a respectful, non-judgemental, anti-racist approach (Horrill et al., 2021). Participants in the CoP not only considered their relationships with their clients, but also used the relationships built within the CoP to build strategies to improve relationships within their practices. As a result, this domain includes themes related to the content of the CoP as well as the processes of learning within the CoP. Three main themes are represented in the data: 1) listening differently (content), 2) deepening learning within the group (process), and 3) modeling accountability (process).

Listening Differently

Over the course of the CoP and following discussions about positionality and power in client relationships, participants described changes in *how* they listen to clients' stories, listening with openness and understanding, and taking the time required to build relationships and focus on clients' strengths. Several participants shared that they are taking more time in their conversations with clients to listen and hear the story from the client's perspective. Rachel described this change like this: "just doing a lot more pausing before I even ask follow up questions and just kind of allowing for space and for time but checking my own assumptions." (CoP #4)

Participants shared that listening differently means taking time to hear clients' stories, understand their strengths and build relationship with them at the outset, rather than diving in to identifying problems. Several shared the value of taking this time early in the relationship, resulting in more effective outcomes later on. Doris described how she is choosing to take more time getting to know clients and hearing their stories.

> That that is a balance. Because, you know, if you take the time here, you miss someone over there. But if you're not present here, are you doing anything at all? You know, like? So I think I, and yes, I know that there's restrictions on this and.... But I would like to err a little bit, I think on building relationship with the client that's in front of me. And I know, it's really, really hard like to... all these clients that are out there, not right in front of me at the moment, but that I know, also need service.
>
> (Doris, CoP #5)

Lena too, described, taking more time to hear the family's concerns and perspectives, to build relationship and understanding, rather than providing recommendations or advice initially. She shared the impact this has had on her interactions with families, building more authentic, collaborative relationships that support clients to reach the goals that are important to them.

> So, I've been doing a lot of screening phone calls, like just connecting with family, so it's over the phone, I don't have any preconceived kind of bias necessarily. And what, I mean, we've got a limited amount of time. And so usually, I hear some buzzwords. And I oft- I go to that file, and here, I'm going to dump this on you, this is what you need to

> do. And what I-I've learned has been way more helpful, does take a bit more time but what has been more helpful is "Tell me more". And that has opened the door to more conversation, I think more authentic conversation too. And you know, when I have shared some suggestions, there were people that said, nobody has ever taken the time to suggest that. I didn't know to do that, or that I could or should do that. And so it's been it's been a really great learning experience for me to not launch into my, here you go, this is what I'm getting paid to do. And it's paid off, I think.
>
> (Lena, CoP #5)

Katrine explained that listening to families with the intent of understanding their overall story and priorities, has pushed her to broaden her practice beyond individual interventions to supporting change within broader systems that impact her clients. She shared how learning to listen differently, helped her to collaborate to find solutions that are manageable for the family, and challenge the systems within which she works when necessary. Sometimes listening differently means helping the family to listen differently as well, offering support to challenge systems and listen to their own intuition.

> And for her [client's mother] to listen differently, because she was listening to the school, right and for, to, for me, it's like, for people to be able to come back and listen to their own inner knowing and inner authority. Like, she's still the mom of this child. She knows what she needs. She knows what her child needs. And yet, she still was feeling "oh, but I really need to do this now. I'm feeling bad, because I'm not doing this." And so

> maybe part of it is also like, giving power back. Right? Like, that's like, “No, you have the choice, you choose what's right.” Instead of “this is what you have to do.”
>
> (Katrine, final interview)

> And I'm a different person for having been part of this community of practice. And, like I said, not all of them are tangible, external ways. But mindset, beliefs, stories that have shifted, to create that space to listen differently and to receive differently, I think that's, like, we can hear words. But when we listen. From our heart with that openness to receive, as it is intended to be heard and received. It feels like that's where I continually grow and expand. And that's been part of through hearing more stories and expanding my understanding. I can continually grow and I'm, I will continue to grow because there is no end point in learning about people or in learning about, and new stories shift and as people's own stories and understanding of their story shifts you, you know, it's just this beautiful thing that I think, at this time and stage in the world, we are in of dismantling these systems that have kept us stuck and boxed in and created so much harm and trauma. Those walls and systems and boxes have been breaking for years now. And they need to.
>
> (Katrine, final interview)

Deepening Learning Within the Group

Engaging in the CoP helped participants to engage with the material differently than through independent reading. Participants learned from each other’s stories and reflections

during the group and were pushed to expand their own thinking and reflections with the support of the group discussion.

> And then you're asked about how participation changed my perspective, and basically, I would say that it has has broadened and deepened my understanding, again. I don't think it like I said, I feel like my journey has, you know, been, you know, kind of gradual, sometimes a little bit, learn a little bit more, a little more quickly. And. And so I think it has helped to just broaden and deepen my understanding and even brought some clarity to my own thinking and my way of practice. Certainly, it's been meaningful to discuss with others. And I find, I think I said in one of the, in one of the sessions that sometimes I come having no idea what I'm going to say…. I was challenged in a good way like to, to think more deliberately about what I'm doing and to be more aware just generally.
>
> (Doris, final interview)

This sense of safety created within our CoP allowed participants to dig deeper and reflect on not only their own learning, but also the presence they bring to their therapeutic relationships. Practice co-creating a safe space for each other and being vulnerable in the group helped them to consider how they create a sense of safety with their clients as well.

> Over the last six months, I feel like every time we met and gathered together and had conversation, there was something a new layer to sort of, for me to consider, to show up differently. And it feels like in a lot of ways, because it there's so much introspection and inner work, but creates outer safety, it's sometimes it's harder to maybe name

> some, some of the impacts, at least for me, because I feel like it's a lot about like, creating culturally, cultural safety is about the space you create, by the presence that you bring, and the openness that you bring. And that's a feeling that people get of if they feel safe or not. It's not a there can be maybe symbols or ways but it i- my understanding, and how I feel safe is the feeling I get in a space as opposed to what is present in that space. And so, what I feel like it's where I am now is the shifting of just how I show up. Maybe some of the questions I ask or how I share or how I speak up. And the understanding and the curiosity I bring to to receiving those stories as well.
>
> (Katrine, final interview)

Participants appreciated the opportunities to dialogue and learn from, and with each other. "I think the thing that I appreciated about this group that was that it was it was voluntary. And so people were there because they wanted to learn and they wanted to be challenged and to change" (Lena, final interview). Several of the participants working in private practice or smaller work communities noted that this group reflection is lacking in their day-to-day work.

> And again, like being in private practice, maybe in some settings and workplaces, there are opportunities for more conversation and sitting in the circle and dialoguing, but being in private practice, and as a sole solopreneur unless they like actively seek out, others to have conversation with those aren't embedded in like, there isn't opportunity. And so I really valued the opportunity to just sit in circle, both to share and to listen and receive. Whether it was from the other participants, whether it was from Robben, Elder

> Mary, Elder Helen like from Yeah, there was. Yeah, it really felt like it was really important to be in conversation together. And that there was this opportunity to dialogue and, you know, feels like there's still so many more things that we could have to like, there's never short a shortage of opportunities to dialogue.
>
> (Katrine, final interview)

Several participants mentioned feelings of discomfort observing racism within their social circles, workplaces or in public but being unsure of how to respond in the moment. Discussions within the group helped to broaden participants understanding of racism including the concepts of micro-aggressions and the manifestations of systemic racism in society. Participants used the group environment to learn to recognize and acknowledge these incidents of racism and rehearse possible anti-racist responses. The group was able to establish enough trust that participants were able to examine our own racist behaviours and examine their origins together. Exploring these topics allowed participants to plan for how we might counter these behaviour patterns in the future and rehearse responses to observed racism in the future.

Modelling of Accountability

Skilled facilitation was key to model relationship and accountability within the group. During sessions facilitators modeled vulnerability and accountability, supporting participants to consider doing the same. Participants observed, learned and experienced how to call people in and be called in, in a good way. Participants were challenged to stretch their own understanding of themselves, their OT practice and the impact their approach has on their

clients. Both Ogai (the trained facilitator) and I (principal investigator) intentionally shared mistakes we had made as examples during discussions about racism and anti-racist responses. This provided opportunities to explore alternative actions and opportunities for growth. Participants shared their own understandings and experiences and discussed how they might respond differently to racism in the future. Some participants also began to identify problematic practices within their own practices, such as Doris reconsidering her use of some standardized assessments and Katrine advocating for flexibility around Kindergarten registration processes.

Several participants shared that they valued seeing how a facilitator can model calling people in without triggering defensiveness, which allowed participants to critically reflect and consider changes to their words or actions. Rachel commented on the language used by the co-facilitators: “And so the way you would phrase questions, invited them to share more versus shut down. So that was also just interesting to watch. And to see how I think education kind of was seeped in, and in a very different way.” (Final interview)

When discussing Doris’ goal coming into the CoP, to discuss difficult topics, she shared that she did feel challenged in the group, in a positive way, and that continued areas of growth potential were highlighted. She hoped for continued anti-racism training and expanded discussion about OT theories and their influence on cultural safety for Indigenous families in future sessions, should the CoP continue. Katrine added that having a racialized facilitator, added another layer of richness to the learning.

> I really appreciated having Ogai's voice and her presence. Because I felt like she was able to ask questions and call-in people in ways that, as a Brown woman, in ways that we as White women sitting around the table just it's not part of our realm. And I really appreciated that. And so I think that was one of the really rich components.
>
> (Katrine, final interview)

Several participants shared that the group helped them to pause, notice, and listen before responding, both in their clinical relationships, but also in the CoP environment. This practice supported more critical reflection and consideration of how they may respond differently in the future. The participants highlighted that they intend to carry this practice forward in their own OT practices and personal interactions.

Consider the Context

The final domain in the Cultural Safety framework challenges healthcare providers to consider the broader context of the client's life including structural barriers, historical trauma, and opportunities to disrupt the status quo (Horrill et al., 2021). For this study, the participants experience of the CoP is also being included in this domain. Within the CoP the themes that arose included: 1) the impact of learning from Indigenous teachers, 2) building courage to find our own roles and take action, and 3) the appreciation of being invited into ceremony and the invitation to continue.

Broadening Understanding

Participation in the community provided participants with the opportunity to build personal connections with Indigenous teachers, Elders and Knowledge Keepers, an opportunity

most had not had outside the CoP. Several participants shared that the stories that these guests offered as gifts for their learning were invaluable in broadening their understanding of the historical experiences of Indigenous Peoples in Canada and prompted participants to reflect on their own understandings, biases and opportunities for growth. While all participants were familiar with the content generally, personal connections made the stories and experiences more meaningful and impactful.

> And so I really valued the opportunity to just sit in circle, both to share and to listen and receive. Whether it was from the other participants, whether it was from Robben, elder Mary, elder Helen like from Yeah, there was. Yeah, it really felt like it was really important to be in conversation together.
>
> (Katrine, Final interview)

The stories shared highlighted two distinct yet connected teachings: the importance of connections to land and place, and the loss of this connection through colonial actions including forced relocations, creation of residential schools and suppression of traditional practices. The connection to land and place was highlighted in the opening and closing sessions of the CoP. Grandmother Helen Robinson-Settee modeled expressing one's positionality through connection to land and community. In doing so, she provided an example for others to consider these connections as well. Two participants shared that this connection to place and community helped them to consider their own history in relation to Indigenous communities that cared for this land before settler arrival. It broadened their understanding of the losses experienced by Indigenous communities and the impacts those loses had on future

generations. Robben Constant's sharing of his family's experiences reinforced a personal connection for many participants. This session was identified as having a strong emotional impact and shifting perspective for several participants.

Finding the Courage to Act

The knowledge that the participants gained in the CoP provided them with the confidence to take more action in their daily lives. One area where they gained confidence to act is in acknowledging and respond to racism when it presents itself, even when it is uncomfortable, to create more safety within their interactions and be part of the solution, rather than part of the problem. Almost all the participants shared that having the opportunity to discuss these sometimes-difficult topics helped them to reflect on past responses to racism, and consider how they would respond "next time". Planning and rehearsing responses was a helpful approach for many of the participants in the CoP and hearing the impact of racism on individuals and families, gave participants the motivation to act with courage "next time".

Learning in a group setting supported some participants to reflect on their own practice differently than they had in the past. The facilitated group environment provided opportunities for sharing, reflection, and problem-solving different responses in the future, at times scripting or rehearsing responses together. Participants shared that the group setting provided support and some expectation of accountability for change moving forward. Doris, Katrine, and Lena spoke of gaining courage to question how things have always been done: examine processes, approaches, and assessments for their value and relevance to the client, rather than a standard procedure.

Both Katrine and Rachel described looking for ways to use the power they hold as White women to amplify and uplift Indigenous clients' voices and serve using the gifts they have, however at times they expressed a fear of doing the wrong thing, holding back or hesitating to engage, because they do not want to cause more harm for Indigenous families. For Katrine, she now feels a responsibility to engage and gently challenge other HCPs when she notices unexamined biases creep into interactions with, or about Indigenous clients. Participating in the CoP has helped her to develop some tools to engage kindly and productively in these situations.

> And, and so, it feels like, through the conversations that we've had, and the dialogues and some of the readings, to really, like, call people in like, it really, that felt like a calling in, because it wasn't calling her out for anything, but just an invitation to view it differently. And maybe think about that parent differently and speak about that parent differently in the future, and the other parents. She encounters, right. And so that's where it feels like the responsibility, like I feel now. Not saying something is being-perpetuating the racism that is happening. And that doesn't create safety. So by speaking up, that will hopefully have these ripple effects of not just creating more safety in my personal interactions with people, but in broader scope interactions.
>
> (Katrine, final interview)

Rachel continues to consider how she can work as an ally to Indigenous people in her personal life. In her OT practice, she proceeds with curiosity, while in her personal life she is working to find a balance between offering her support or service without intruding in

Indigenous spaces. She was hoping to find answers within the CoP for how to proceed, but instead came away with more questions, and a small community to share them with.

Engaging in Community and Ceremony

The CoP integrated small pieces of ceremony and Indigenous ways of Knowing, Being and Doing with the help of generous Indigenous teachers. Over the course of the last CoP session and final interviews, all participants expressed an appreciation for this gift and most indicated a desire to continue learning through attendance at ceremony when invited. When speaking about their ongoing learning through ceremony, participants expressed varying degrees of comfort joining when invited. Concerns around intruding on a space not intended for non-Indigenous people, and nervousness around not knowing the protocol when attending, prevented some participants from attending ceremonies when invited in the past (prior to engaging in the CoP). Several participants shared that while they are now more comfortable with some aspects of ceremony, such as smudging, they would be more likely to attend other ceremonies or community gatherings if they could go with another non-Indigenous person who was familiar with the protocols. Fear of making a mistake and causing offense or harm was cited as a reason not to attend even when explicitly invited to attend. Several participants shared that, having now gotten to know three Indigenous teachers and ceremony people during the CoP, they would be more likely to attend ceremony with those teachers when invited.

Two aspects of the teachings shared by Indigenous teachers during the CoP stood out to participants: the teaching around smudging and the personal stories shared. Grandmother

Helen's teachings about smudging, the medicines used, why it is done, and how to do it when invited, was helpful for participants to understand the process and meaning of smudging and to practice smudging in a teaching environment. Elizabeth had shared during her initial interview that her lack of experience with smudging had prevented her from participating in the past. While she was unable to continue the CoP beyond the first session, other participants shared an appreciation for the gift of the additional teaching around smudging, rather than beginning with a smudge without context. This teaching helped some to feel more comfortable participating in a smudge when invited.

Hearing the personal expression of relationships, connection to land and disconnection from those places helped some participants realize the importance of sharing their own background and positionality with the families they work with. Participants expressed gratitude for the vulnerability required for CoP guests, Indigenous teachers, to share the personal stories they did, and how meaningful the personal connections were to participants. Participants spoke of the value of these personal connections in helping them to understand the impact of colonization, government policies, and interpersonal racism.

> I think it's like…experiential learning to just really be invited to participate, but then also just observe and learn and appreciate that, and all the lessons, the teachings the offering, and that she's [Mary Wilson] willing to invite us in feels like a really big honour.
>
> (Katrine, final interview)

Reflexivity: The Story of My Learning Journey

I have shared my positionality at the outset of this document as a way for the reader to understand my social location and motivations as I entered this journey. In this section I hope to share some of my learning journey and consider how my role as researcher, CoP co-facilitator, and co-participant has impacted this project. I begin by sharing my reflection from the final CoP session as context for this section. We were sharing reflections on the questions posed by Senator Murray Sinclair (2014), as his Elders had posed to him: “Where am I going?” and “What is my purpose?”.

> Where am I going? I started my master's work- this project was a seed that got planted in a discussion with a couple of other White settlers who are looking to do better at work and in our personal lives and challenge each other. And so that's what kind of cued me, that discussion cued me to go and talk to Mary about starting this a- starting my work or moving to the next phase of my work. And so where I'm going, I think is first, to finish this project and, and see where, where this will take us. But then, in the long run, I hear- you say this a lot, Mary, is if you make it safer for Indigenous children, you make it safer for all children, right? Because when you're looking at what is needed for authentic care for a child and their family, in whatever location they are, in whatever situations they are, if you can do that for one family, you can do that for all the families that you work with, right or I can do it for all the families that I work with. And so that is kind of the path that I'm going on. I have been very privileged along that path, to be welcomed into a loving community, as a learner and a helper, and to be joined on that pathway with all of you. I learned, I learn more every day about the worldview that is different than mine, and my Western colonized ways, and I appreciate the ways that it has helped us to stretch myself and grow…

> And then my purpose, I feel like is to listen, listen. I think a few of you said that, but, and to listen to, in this case, Indigenous communities and hear what is being said and what is needed, and how I can be the best support, how I can walk alongside, to use my power and unearned privilege to challenge the status quo and to challenge myself in order to support the directions chosen by the indigenous communities in this situation. And I feel like I have a tendency to just want to do. And so that is my purpose, but also my challenge is to listen first, and walk alongside, not do for, not take over, but to walk together. And so I came to this project, hoping to advance truth and reconciliation in OT practice in a small way. But I've gained so much more in the relationships, and friendships and experiences than I'll ever be able to give back. So yeah, it will continue long after my thesis is done.
>
> (Chris, CoP #6)

Over the course of the community of practice, I had the privilege of learning alongside my occupational therapist colleagues as well as from Indigenous teachers and community members in ceremony. I have witnessed the importance of relationship and reciprocity in community and have reflected on the importance I place on relationship in my own life. As I acknowledge how I intentionally prioritize relationship with my family and colleagues, I have begun to integrate relationship building more explicitly into my professional practice with clients as well. Through reflective practice, I've realized that I have room to grow to center relationships with clients and families, especially when we have differing views. Through this focus, I have been able to understand my clients' priorities better and collaborate more effectively to meet their needs.

My Research Ceremony

As I look back on how I influenced this research and how it influenced me, I consider the research ceremony that I committed to at the outset: meditation to focus my intentions; time spent outside to connect to and learn from the teachings of the land; and reflecting on my new understandings through journaling and discussion with Grandmother Mary. I have been very consistent with my meditation practice and time spent in nature. The journaling component of this ceremony is harder for me (and always has been), as such, there have been ebbs and flow in my journaling to capture my learning. More recently, I have found that engaging in discussion about the seasonal changes, my observations, and my new understandings with my colleagues and family has acted as another form of reflection. I have found having these discussions also have a reciprocal nature, not only extending my personal reflection, but also aiding colleagues, friends, and family to reflect on their experiences and roles in truth and reconciliation.

One additional piece of my research ceremony has evolved over the course of the research project: building relationships and connection to community. I began attending Full Moon Ceremonies as a commitment to Grandmother Mary, to the community that welcomed me, and to myself. As I attended these ceremonies, I was welcomed and surrounded by members of different communities who accepted me in my learning capacity, and allowed me to walk alongside them, even when I made mistakes. This connection to monthly Full Moon Ceremonies with Grandmothers Mary and Helen, and later attendance at Sundance Ceremonies at Spruce Woods and York Factory First Nation, allowed me to build relationships, learn from Indigenous community members directly, and give back to those teaching me

through service. These personal experiences of deepened relationships, connections, and reciprocity through service have influenced my practice, my research, and enriched my personal life the most.

Letting Go of My Agenda, The Dual Role of Researcher and Participant

My dual role of researcher/co-facilitator and participant in the CoP challenged me to consider not only the literature and stated needs of Indigenous communities in accessing culturally safer health care, but also the learning needs of myself and the group of occupational therapists who joined the CoP. My role as a researcher was to gather the stories of participants and make meaning of them in a way that is authentic to the participant's experiences. My role as co-facilitator was to help guide the conversation through the important topics, allowing time for discussion and supporting the learning of the group members. Finally, my role as participant was to learn alongside the others, allowing myself to be challenged and stretched.

Supporting participants to learn and grow in an environment that was challenging, yet safe enough to proceed with difficult topics, meant moving at a pace that worked for the group. This pace was often slower than I had anticipated, not because the participants struggled with the concepts but because we needed time to process and explore together. I had underestimated the preparatory learning I had engaged in while immersing myself in these concepts and topics for more than a year at the time that the CoP began. Each of the other participants came with their own understandings and previous learnings, We all needed to share those disparate pieces and build common understanding of each concept. This process takes time. Letting go of my agenda, of the tasks to be completed in each session, was

challenging for me. I wanted the learning experience to be rich and meaningful, and initially developed very full agendas. As the sessions progressed and through reflection with my co-facilitator, Ogai, I realized that allowing the conversation to happen organically with loose guidelines to stay on topic allowed for more meaningful discussion than moving strictly through a rigid schedule. I learned to let the participants take the time they needed for conversation and allow the lessons to surface in their own time. This included acknowledging that the CoP was not the end of our learning journeys, rather a step along the path.

This act of letting go of my agenda has been reinforced, time and time again throughout this study – as has the need for persistence and accountability. During the CoP sessions, my drive to move ahead was motivated by accountability to the participants and guests who were giving of their time. During the analysis and writing phases of the project, family health and professional commitments often took priority over the writing process. Letting go, in these cases, required a combination of self-compassion and accountability: self-compassion to take the time needed to care for my family and accountability to persist with the research I had started, rather than to let it sit incomplete. Taking time from the project allowed me to attempt to maintain balance in my life, while remaining accountable for my research outcomes. The additional time my research took also allowed me more time to learn alongside the Indigenous community members who welcomed me into ceremony and community. Letting go of my agenda brought me to deeper learning about relationship and community.

Humility and Ego

Reflecting with my advisors and co-facilitator, there were times when I expressed frustration at what I perceived as the slow pace of our progress as a group. As we discussed these feelings, I heard tones of impatience and judgement in my words. It was through sharing these experiences and reflecting on them together (and sometimes just through saying them out loud) that I was able to identify the hypocrisy and ego of, however briefly, believing I had "arrived" or was further along the journey towards becoming a culturally safer occupational therapist. In these moments, I was reminded of the ultimate goal of this project- to support improved healthcare for all Indigenous children and their families through culturally safer care. Each of the participants in this study have our own path and are traveling together, supporting each other and holding each other accountable. It is not a competition, and I am by no means finished my journey.

Relationship and Reciprocity

Personally, I have gained so much more than I anticipated I would from this project. My involvement in the CoP has pushed me to have more explicit conversations about racism, health inequities, and social justice in both my personal and professional life. As with other participants, I have been challenged to reflect on moments of my own inaction or missteps when addressing anti-Indigenous racism in both interpersonal and structural contexts. These moments of reflection created opportunities to consider how I can do better in the future and allowed me to plan for different responses the next time I enact or witness racism. I have come

to understand more deeply that my own inaction has caused harms, and I commit to action guided by Indigenous voices in future opportunities.

Alongside acknowledging and being accountable for my own errors, I have had the opportunity to develop relationships with Indigenous community members. These relationships have grown organically, following engagement during the community of practice, including invitations by Robben Constant and Mary Wilson to attend and help at Sundance Ceremonies. These opportunities allowed me not only to give back to these teachers through service, but also to immerse myself in ceremony and build new relationships with other community members, broadening my circle of relationship, accountability and reciprocity.

My Teachers

Over the course of this research project, I benefited immensely for the time and teachings of Indigenous and racialized teachers. As a White settler woman, these teachers helped me to explicitly acknowledge my Whiteness and my worldview. Given the ongoing tendency of White learners to expect that racialized groups teach us how we can do better without compensation or acknowledgement; I wanted to take a moment to pause and acknowledge how each of these teachers contributed to this project and my learning.

Mary Wilson

I benefitted from the mentorship and preparatory conversations held with Knowledge Keeper, Grandmother, Dr. Mary Wilson. She helped me to reflect on the different worldview I come from as White settler and helped me to center the Indigenous communities that I hoped this project would ultimately impact in each conversation. Mary modeled relationship and

reciprocity in her invitations to ceremony, gifts of time, healing conversations, and her teachings around service and community. I have come to know and love her during our work together and commit to continuing this reciprocal relationship of teaching, learning, and service.

Helen Robinson-Settee

Grandmother Helen has shared teachings about "the good life" with me in preparation for the CoP, during meetings at work, and in ceremony. She models this worldview in each interaction with me and others. Helen thoughtfully worked to incorporate ceremony into her time with the CoP, ensuring that the CoP members had opportunities to experience ceremony in an environment which modeled respect and created a safe space for questions.

Helen and Mary both taught me protocol for engaging with Indigenous Elders and Wisdom Keepers and gently corrected me when I have made mistakes. These kind corrections and reminders are cherished gifts that I will carry on into each new interaction I have.

Robben Constant

Robben not only shared his and his family's story with the CoP, but he also invited me to meet his family and community. As Sundance Chief of the Whirling Blizzard Sundance in York Factory First Nation, Robben welcomed me and my family into his Sundance family. He shared teachings, time, and friendship with me. He also allowed me to give back to him and the community, using my gifts of service.

Ogai Sherzoi

Ogai Sherzoi, my CoP co-facilitator, facilitated meaningful conversations both in the community of practice and afterwards while we debriefed. As the only racialized person in the room for all the community of practice sessions, Ogai gave generously of her personal perspectives and experiences while acknowledging that they are also different from those of Indigenous people in Canada. Ogai gently challenged us, as White women participants, to consider our privileges and to question our assumptions and biases when working with racialized communities. Ogai modeled "calling people in" to conversations which facilitated accountability and understanding over judgement and shame.

Angie Phenix

Indigenous occupational therapist and scholar, Angie Phenix challenged me (and others) to consider how the term "cultural safety" continues to center Whiteness and acts to "other" racialized groups including Indigenous people. These conversations were brief yet meaningful, and I continue to contemplate them in consideration of how I will continue with this work. Going forward in conversations about cultural safety and culturally safer healthcare, I will ensure that I acknowledge the inherent othering that is caused by the term and be more explicit in which component(s) of cultural safety I am addressing (for example: power imbalances, relationship building, anti-racism). Identifying the specific harm or attribute, rather than choosing a global term may be one way to move away from "othering" and toward accountability and change.

Discussion

Becoming culturally safer healthcare providers involves an ongoing journey of critical self-reflection, collaboration with clients and families, and active change on the part of the HCP, rather than participation in a one-time course (Bourassa et al., 2020; Papps & Ramsden, 1996; Ward et al., 2016; Wylie et al., 2021). This study sought to explore the impact of an Indigenous Cultural Safety CoP on the attitudes, beliefs and reported practices of pediatric occupational therapists. An additional objective was to explore how the CoP model influenced participants on their journey to culturally safer care, and the strengths and limitations of using a CoP model. Grounded in constructivist and Indigenist epistemologies, this narrative inquiry explored participants' stories of their journeys towards culturally safer care. The Cultural Safety Framework provided a helpful lens to describe the key areas of learning that occurred.

In this discussion I will: (a) summarize the impact of the CoP on the overall learning of the participants. I will relate the learning arch of this group of participants to the literature to highlight the similarities and differences from that which has already been described in the literature. (b) Discuss the benefits and challenges of using the Cultural Safety Framework for structuring the CoP and provide recommendations for future use of the Cultural Safety Framework for this purpose. (c) Discuss learnings about the use of a CoP for learning about Indigenous cultural safety and provide some considerations for clinicians and policymakers in using a CoP model in the future. Since there is little written about using a CoP for this content area, this can inform others wishing to try this model for the purpose of cultural safety and anti-racism education. (d) Finally, I will describe strengths and limitations of this study.

Impact of the CoP on Participants' Learning

There are very few studies (Shahram et al., 2022) that have explored the format of a CoP on participant learning related to anti-racism. The results of this study provide further insight into the learning process within a CoP regarding anti-racism for a group of White settlers than is currently available in the literature. In this study, participants shared the stories of their journeys toward cultural safety through the telling of their own stories and in the sharing sessions within the CoP. Despite the varied experiences participants had with ICST and their clinical experiences at the outset of the CoP, this format was effective at prompting the participants to develop new understandings of their positionality, privileges and power in society, the impact their social location has on relationships with clients, and recognition of the social and structural barriers which Indigenous families must negotiate on a regular basis. Additionally, each participant described the importance of continued engagement with ICST in the future and committed to continued learning, discussion, and practice changes going forward.

These findings indicate that the CoP format has promise for clinician growth in ICST. It is a format that allows for the ongoing reflexivity and engagement with ICST that are necessary to facilitate changes in healthcare providers' attitudes and beliefs (Browne et al., 2015, 2018, 2021; MacLean et al., 2023; Robinson-Settee et al., 2021; Wylie et al., 2021) in order to improve healthcare experiences and health outcomes for Indigenous people (Henderson et al., 2018; Truong et al., 2014; Wylie et al., 2021). While new healthcare providers are receiving initial ICST in their post-secondary professional education (De Leeuw et al., 2021; Herzog et al., 2021;

MacLean et al., 2023), the CoP offers a format for clinicians to engage in ongoing learning around culturally safer care once in professional practice and supports practitioners to engage in lifelong learning for culturally safer care throughout their career.

The rich description of the participants' learning journeys in my study give insight into how the CoP format supported learning. The CoP format (using the Horrill et al. (2021) framework which will be discussed further later) allowed the participants to engage in reflexivity and exploration of power dynamics in ICST which are key concepts to explore (Browne et al., 2021; Curtis et al., 2019; Horrill et al., 2021; Ward et al., 2021) in anti-racism training (Shahram et al., 2022). Participants' stories reflected not only the motivations they had for engaging in ICST, but also shared the impact that discussions about positionality, social location, and privileges had on their personal and professional lives. The CoP format allowed participants to take the necessary time to revisit the core concepts of ICST, even those that started the CoP with a higher level of self-awareness than others. The CoP format encourages participants to learn with and from each other, so that regardless of where someone was in their learning journey, the content was relevant to them, as they engaged in the content in different ways – as new learners, mentors or supporters. In relation to learning about power, several participants indicated that the CoP had impacted how they understood their relationships and their client interactions, and that they were making shifts in their practice to balance the power dynamics between themselves and their clients.

One of the most impactful teaching and learning strategies from the perspective of the participants was the inclusion of local Indigenous community members as teachers and as a

bridge to Indigenous communities and ceremony that participants could continue to engage in outside of the CoP. This confirms findings shared by Wylie et al. (2021) and Yaphe et al. (2019) about the importance of personal interactions to build connections and sensitize healthcare providers to the local needs of Indigenous community members. In the ICST program evaluated by Yaphe et al. (2019), an Indigenous Elder acted as a co-facilitator and integrated ceremony at the beginning of each session. Evaluation outcomes indicated that this was a highly valued component of the ICST program (Yaphe et al., 2019). Similarly, participants in the CoP expressed appreciation for the opportunity to hear directly from Indigenous presenters about their own history and to learn from Indigenous knowledge keeper and teachers about ceremony. In the small group sessions, participants were able to make personal connections to Indigenous teachers that some had not been able to access outside the CoP. This CoP followed the recommendations of Erich Steinman (2020) who supports the inclusion of Indigenous teachers in ICST education. Despite the need for settlers to work to educate themselves and their fellow settlers, not including Indigenous teachers in the process of education risks perpetuating harmful colonial narratives, rather than re-educating settlers in a decolonized way (Steinman, 2020). While I tried to find a balance in this CoP by including a Knowledge Keeper in the planning of the sessions, and integrating Indigenous Knowledge Keepers into the sessions, this could be enhanced by having a longer CoP, which includes well trained (and compensated) Indigenous facilitators in every session.

Using the Cultural Safety Framework to Structure the CoP

The Cultural Safety Framework, adapted from Horrill et al.'s (2021) work provided structure, content, and an intentional order for planning the content of the CoP. While the framework was originally designed as a pathway for individual HCPs to consider when working with their Indigenous clients (Horrill et al., 2021), the funnel visual used in the adapted framework for this study (Figure 1), showed how the group moved between content areas, revisiting earlier topics as participants deepened their learning with each session. After reviewing the findings in this study, a lightning bolt was incorporated into the Cultural Safety Framework to symbolize "becoming unsettled" (Figure 2). The lightning bolt indicates the presence of a catalyst for engagement with ICST. The term becoming unsettled implies feelings of discomfort/ dis-ease which are necessary to acknowledge and engage with in order to move towards action (McGuire-Adams, 2021; Regan, 2010; Steinman, 2020).

This study did not explore ways to facilitate initial interest or engagement in ICST, however once HCPs become engaged, a CoP can help them to respond and engage with the dis-ease of becoming unsettled in productive way; leaning on each other to learn, un-learn and re-learn about colonization and the responsibilities settlers hold in disrupting racism within systems and within their lives (McGuire-Adams, 2021; Regan, 2010; Steinman, 2020). As mentioned in the findings, this unsettling can be a sudden understanding which leads individuals to seek out or engage in new learning, or it can be a slow awakening that grows over time. No matter the speed, this unsettling helped participants engage in reflexivity about their own positionality, privileges and power and the impacts these have on their relationships with

Indigenous clients. Moments of discomfort and unsettling within the CoP can reinforce the participants' decisions to pursue participation in ICST, creating opportunities to engage in the other domains.

The other domains of the Cultural Safety Framework, *practicing reflexivity*, *focusing on relationship* and *considering the context,* were clearly described in each participant's learning journey, indicating that these content areas were relevant and a catalyst for learning. A helpful aspect of the Horrill framework was that the framework domains helped to ensure that the discussions during the CoP considered intrapersonal, interpersonal and broader contextual factors when exploring how each participant could work towards culturally safer practice (Horrill et al., 2021).

Adapting the structure of the Cultural Safety Framework (Horrill et al., 2021) to allow for movement of learning back and forth between reflexivity, relationship and context, rather than addressing these in a linear way, allowed participants to revisit previous topics and expand their own understanding of the concepts as the CoP progressed. One example of this fluidity between domains is when participants revisited their social location and understandings of privilege and power when discussing systemic racism. Participants were able to acknowledge their experiences differ from those of their clients and are impacted by the unearned privileges they carry due to their (White) race. This points to the importance of a circular learning process for ICST which supports deeper and deeper reflexivity.

The Horrill et al. (2021) framework has more to offer than we were able to use on our time-limited CoP. It includes reflexive questions that may be a helpful tool to explore within the

CoP setting. Further, in our time-limited CoP, we only scratched the surface of considering how to alter or approach practice in a different way. Should a CoP continue on a long-term basis, a natural progression of content may include case studies or examples from participants' own clinical practices. Using the pathway, as Horrill et al. (2021) presented it could be helpful to examine past clinical challenges, assist the HCP to engage reflexively with the situation, and consider how the HCP may have contributed to conflict or poor outcomes in ways not previously considered. Offering a tool for participants to reflect on their own practices and approaches, may support individual work of reflexivity, and could act as a tool to engage in culturally safer practices in the future.

Horrill et al. proposed the "cultural safety and trauma- and violence-informed framework for redressing inequities in healthcare access" (2021, p. 6) as a tool for nurses to examine themselves and their own practices in order to address intrapersonal, interpersonal and systemic barriers to culturally safer and trauma- and violence-informed care (TVIC). It was a very useful framework to create a content structure for the CoP. However, the findings from this study indicate that while this content and framework is a very helpful learning tool, it is important to create a relationship-oriented learning environment so that the participants can experientially learn about these concepts in a supportive environment.

Using a CoP Model for Indigenous Cultural Safety and Anti-Racism Training

This study reinforced findings in the literature of the aspects of a CoP that positively support anti-racism training by bringing together a community of learners (Shahram et al., 2022). The CoP structure allowed the participants to go further in their learning than what they

could have done at an individual level. Shahram et al. (2022), who reported on an evaluation of an anti-racism CoP held virtually due to the global pandemic, describe similar benefits of gathering together as a community of learners as was found in this study, such as gaining courage through practice, exposure, and group support. Participants in the virtual CoP gained not only new knowledge and skills, but confidence in their ability to engage in anti-racist action in the future (Shahram et al., 2022) indicating that they had similar benefits to the CoP in my study which was held in person.

Another aspect of this CoP that has been found in the literature to date, is the importance of Indigenous teachers and hearing experiences directly from Indigenous Elders and community members (Yaphe et al., 2019). The importance of the development of a community of learning is also reinforced by the negative findings in a study by Yaphe et al. (2019). In their pilot project that offered three, three-hour Indigenous cultural safety modules to groups of 20-25 multi-disciplinary healthcare providers, the groups were too large to establish group discussion and prevented participants from asking questions and engaging openly (Yaphe et al., 2019). Despite our much smaller groups, our CoP sessions frequently ran long or did not cover all the content planned for each session, highlighting the need for adequate time to fully engage in discussion and reflection during the CoP sessions.

Yaphe et al. (2019) also found that some participants expressed feeling judged due to their race and profession within the sessions that discussed prejudices and Indigenous Peoples healthcare experiences. This may speak again to the benefits of a smaller CoP format, or to the importance of integrated Indigenous Knowledge Keepers, or a combination of the two, since

each participant was able to meet and make personal connections with the Indigenous teachers and Knowledge Keepers, which may have helped to reduce the reactive responses noted by Yaphe et al (2019). However, participants may not have shared such feelings with me, knowing the multiple roles I held in the study (primary researcher, co-facilitator) and my personal relationships with the Indigenous teachers that joined us.

A known limitation of White settler-only groups for anti-racism learning is that it risks creating a space which focused on White people's emotions, perpetuating myths about White meritocracy and virtue signaling to each other rather than engaging in genuine critical reflexivity and striving for change (McLean, 2017; Slater, 2019; Steinman, 2020). We attempted to counteract these challenges by engaging a co-facilitator with skills in anti-oppressive approaches to research (Roche et al., 2020) and by integrating Indigenous Knowledge Keepers and teachers in half of the CoP sessions. While participants in the CoP noted the lack of diversity within the participants, some participants also found a sense of safety, as they worried less about saying something that may hurt racialized participants. While participants shared that they would welcome more diversity among the participants in the CoP, some were able to identify the potential for harm to others if the CoP was not well moderated. Some participants shared that Indigenous or racialized participants may be at risk for additional trauma, given that the White women were working through their (our) questions and concerns. These concerns illustrate the findings shared by Ward et al. (2021) regarding the importance of engaging well trained facilitators to help create a sense of safety for all, especially Indigenous or other racialized participants and educators. Ward et al. (2021) highlight the risk of harm to both

Indigenous educators/ facilitators and Indigenous participants if resistance to concepts of colonialism and the realities of racism experienced by Indigenous people are challenged in the classroom. The risks and benefits of homogeneous versus heterogeneous CoPs need to be carefully considered and planned for by the facilitators or leaders of CoPs that address the sensitive topic of anti-racism, and these risks and benefits need to be made overtly to the participants. Funders of future Indigenous Cultural Safety CoPs must ensure that these risks and benefits have been carefully thought through and that sufficient resources have been allocated to ensure facilitators are well trained in the content and methods of ICST. Additionally, resources including personnel and funding, should be available to support the Indigenous teachers/ guests when, not if, they experience trauma as a result of the education they are providing. It is anticipated that as the diversity of participants and size of the CoP increase, these resource needs will increase as well (Ward et al., 2021; Yaphe et al., 2019).

Strengths and Limitations of the Study

Strengths

This study has several strengths. First, cultural safety has a well-established definition with consensus within the literature around core components required in cultural safety training (ICST) to guide the curriculum (Bourassa et al., 2020; Browne, 2017; Papps & Ramsden, 1996, 1996; Ward et al., 2021). The curriculum was based on core components of cultural safety identified in the literature specifically, addressing power, privilege, equity and racism, and integrated Indigenous perspectives and experiences into the sessions (Churchill et al., 2017; Curtis et al., 2019; Horrill et al., 2021; Ward et al., 2021). Participants were provided with

general topic areas and highlighted their own learning needs, allowing for some customization to the needs of the participants and provided a positive yet challenging learning environment.

Second, this focus on the core components of ICST rather than awareness about Indigenous Peoples in general, helped to resist a pan-Indigenous approach to the community of practice (Browne et al., 2016). Teachings shared by Indigenous guests were specific to their personal experiences and highlighted their background, social location, worldview, and experiences. This allowed for discussion about the diversity of perspectives, experiences and understandings under the umbrella of "Indigenous".

Third, the use of both Indigenist and constructivist epistemologies supports the integrity and rigour of the research. Using Indigenist epistemologies helps align my work to the values of the Indigenous communities it will impact, and guides me to consider my accountability to Indigenous children and their families (Rix et al., 2019). The constructivist epistemology supported me to explore the stories of participants, varied meanings attached to those stories and provides a structure to share those stories in a systematic way (Creswell, 2014; Crotty, 1998).

Fourth, in accordance with Indigenist research approaches, this study attempted to turn the gaze onto the perpetrators of harm, healthcare providers, rather than examine the Indigenous children and families being harmed (Potts & Brown, 2015). Engaging an Indigenous Wisdom Keeper on my advisory committee as well as Indigenous teachers within the CoP helped to guide the work and center Indigenous knowledge within the project.

Limitations

The study limitations include first and foremost, given the scope of this study, I was unable to gather feedback from the Indigenous families receiving care from the participants, who would ultimately be able to determine if care has become safer. Given the changes in attitudes, beliefs, and goals for continued action reported by participants, further study including feedback from Indigenous families and communities as well as longer term studies exploring sustained behavioural changes among HCPs are needed.

Established, evaluated curriculum for continuous engagement in cultural safety training is not available; therefore, the curriculum used in the CoP is a collection from a variety of sources. While the tools used have been described in the literature, they have not been combined in this way. The benefit of this approach is that the curriculum can be adapted to the learning needs of the participants and feedback from the facilitator and Indigenous Wisdom Keepers involved. As recommended by Churchill et al. (2017) a reference list of all materials (Appendix A) used was kept as documentation of the curriculum should further evaluation of the materials be attempted.

While the study sought to identify changes that participants implemented into their own practices, the duration of the study was too short to observe longitudinal impacts on participants' practices. Participants were able to identify changes in their attitudes and beliefs, however most changes to practice were at a contemplative stage during final interviews. Participants were able to share early attempts to change their own practice in some cases

however a longer study or a follow-up study would be required to determine if these changes were operationalized or sustained.

The study focused on individual occupational therapists and their attitudes, beliefs, and reported changes. It is understood that wider systemic changes must also take place to minimize barriers to care and reduce or ideally eliminate harm to Indigenous families due to culturally unsafe care (Balcazar et al., 2009; Browne et al., 2022; Diffey & Lavallee, 2014; Public Health Agency of Canada, 2019); however, system level issues were beyond the scope of this project. A longer-term study incorporating community feedback is key determining the ultimate success of this model- culturally safer care for Indigenous children and families.

Finally, I am not an expert in cultural safety. I continue to learn and consider my impact each day. Most recently I have been challenged to consider the use of the term “cultural safety” as it continues to center Whiteness and “other” Indigenous and other racialized groups (May & December, 2024, personal communication, Angie Phenix). I continue to reflect on the terms used and the unrecognized (by me) harms that they cause. While I was unable to address this concern for this project, I am considering more clear language in my own practice and future projects. I will continue to seek guidance from community leaders and clients alike to ensure Indigenous families feel welcomed and safe accessing healthcare and consider how my language (and the language of the broader systems) can hinder or facilitate this sense of safety.

Conclusion

Acknowledging that becoming culturally safer healthcare providers involves an ongoing journey of self-reflection, collaboration with clients and families, and active change on the part of the HCP, rather than participation in a one-time course**,** this study sought to explore the impact of an Indigenous Cultural Safety community of practice on the attitudes, and beliefs of pediatric occupational therapists, and reported changes to their practices. An additional objective included exploring the value of the CoP model for ICST.

This study provided an opportunity for six pediatric OTs (including myself) to travel together on a journey towards culturally safer occupational therapy practice. Although participants were at varying points along the journey, each shared meaningful changes to their own understanding of Indigenous cultural safety. Changes in attitudes and beliefs were reported during the community of practice, while practice changes were just beginning to unfold. It is anticipated that a longer CoP may have allowed for further integration of attitudinal changes into practice.

The revised cultural safety framework provided a flexible structure to address core components of Indigenous cultural safety training within a group setting. Future cultural safety CoPs may benefit from explicit integration of the framework into the formal structure of the curriculum. The addition of the “become unsettled” domain may help participants to identify their own motivation for their engagement with ICST, which may in turn help them to continue on with the learning even as topics become emotionally challenging.

The structure of a CoP mirrors the processes that are needed for culturally safe care and thus the format allows for both ICST content and process learning that is essential to developing culturally safer occupational therapists. The CoP offered opportunities for accountability between members and continued learning. Participants valued the group discussion in addition to the opportunities to learn from Indigenous community members and teachers.

Future research should include feedback from willing communities/ clients in order to determine if the changes reported by occupational therapists had a positive impact on the care Indigenous children and families experience on a daily basis. Positive change for Indigenous children and families is the ultimate goal of this project and any Indigenous cultural safety training.

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Appendix A

Community of Practice Curriculum and Resources

The curriculum for the community of practice (CoP) was be based on the core components of Indigenous cultural safety training identified in the literature and the Cultural Safety Framework guiding questions (Horrill et al., 2021). Specific activities were chosen in accordance with the expressed learning needs of the participants in the CoP and based on feedback from the invited Wisdom Keeper(s) and CoP facilitators (myself and a facilitator hired through the George and Fay Yee Centre for Healthcare Innovation). CoP participants were encouraged to share relevant resources and activities to support a collaborative learning environment.

Below is a brief summary of the content of each session. Table A1 describes the curriculum content and how it corresponds to the cultural safety conceptual framework and core components of ICST described in the literature. A reference list for the CoP tools and resources follows the table.

Community of Practice Session Summary

Session 1: Introductions

- Smudge teaching
- Sharing Circle: Who am I? Where do I come from?
- Creating safe spaces: Discussion about group guidelines
- Positionality: Perspective exercise
- Presentation Cultural safety framework

Session 2: Power, Privilege and Anti-Racism

- Sharing circle: Describing social location, intersecting identities, areas of power and privilege. How does your positionality influence your interactions with families?
- Identifying power, privileges and biases.
- Principles of anti-racism.

Session 3: Biases and Stereotypes, Anti-racism

- Sharing circle: Where do you witness racism and how do you respond?
- Anti-racism discussion including biases, stereotypes and personal actions.

Session 4: Historical and present-day context

- Sharing Circle: Consider your own personal biases. How am I challenging myself to grow and change toward integrating anti-racism and cultural safety within occupational therapy?
- Presentation by Robben Constant- Intergenerational Impacts of Colonization, joined by Knowledge Keeper, Mary Wilson.

Session 5: Building relationship and strengths- based perspectives

- Sharing circle: How do you build relationships with clients and incorporate their strengths into your practices?
- Deconstructing our language exercise

Session 6: Closing with Ceremony

- Sharing Circle: Where am I going? What is my purpose? Moving forward with becoming culturally safer practitioners.
- What actions do you plan to take moving forward?
- Feast

Table A1

Community of Practice Curriculum Outline

Session	**Content**	**Resources**	**Cultural Safety Framework Domain**	**Core Components of ICST**
One	Introduction: - Smudge teaching by Helen Robinson-Settee - Opening sharing circle based on the great questions of life - Introduce cultural safety framework - Defining culture - Positionality reflection exercise	(Ariano et al., 2021a; Dawson et al., 2022; Horrill et al., 2021; Papps & Ramsden, 1996; Sinclair, 2014; M. Wilson & Robinson-Settee, 2021; S. Wilson, 2008)	Intrapersonal Domain	Reflexivity
Two	Privileges, power and anti-Racism - Power and privilege exercises - Understanding racism - Life-long journey Anti-racism Tea House resources	(Clarke, n.d.; C. P. Jones, 2000; McGibbon, 2018; Okun, n.d.; Reading, 2013; Shahram et al., 2022)	Intrapersonal Domain and Interpersonal Domain	Reflexivity Anti-Racism
Three	Biases, stereotypes, power, and privilege - Power and privilege exercises Identifying, replacing stereotype	(Clarke, n.d.; McGibbon, 2019; Nixon, 2019; Shahram et al., 2022)	Intrapersonal Domain and Interpersonal Domain	Reflexivity Relationship Focused Power Sharing

Four	Historical and present-day context Guests: Robben Constant, Mary Wilson	(Ariano et al., 2021a; *Healing the Hurt*, 2020; MacCormick, 2021)	Interpersonal Domain and Structural Domain	Relationship Focused Contextual Awareness
Five	Relationship building, strengths-based approaches - Language use - Deconstruction exercise	(Horrill et al., 2021; Sjorberg & McDermott, 2016; S. Wilson, 2008)	Interpersonal Domain	Relationship Focused Power Sharing
Six	Closing - Sharing circle based on the great questions of life with Helen Robinson-Settee and Mary Wilson - Commitments to future action - Feast	(Horrill et al., 2021; M. Wilson & Robinson-Settee, 2021; S. Wilson, 2008)	All domains	All

Community of Practice Materials List

- Cultural safety framework (Horrill et al., 2021)
- Anti-racism response training (Tazumi et al., n.d.)
- Bystander anti-racism (Nelson et al., 2011)
- Calling in vs. Calling out(Omiya, n.d.)
- COTM Cultural Humility Resource (Ariano et al., 2021)
- Cycle of Socialization (Harro, n.d.)
- Deconstruction Exercise (Sjorberg & McDermott, 2016)
- Education: Cause and Solution (Sinclair, 2014)
- Let's talk whiteness and health equity (National Collaborating Centre for Determinants of Health, 2020)
- Occupational Therapy Roles in an Indigenous Context: An Integrative Review (White & Beagan, 2020)
- Power Exercise (Clarke, n.d.)
- Putting Ourselves Forward (Absolon & Willett, 2005)
- Stories of Pediatric Rehabilitation Practitioners With/in Indigenous Communities (Byrne et al., 2020)
- White Privilege: Unpacking the Invisible Knapsack (McIntosh, 2019)

Appendix B

Sample Reflexive Journaling Questions

- Describe your social location. (Clarke, n.d.)
    - Consider the intersecting identities you hold as well as areas of power and privilege.
    - How may your positionality influence your interactions with the families you work with?
- What attitudes, values and beliefs do you hold about people that are different from you (e.g. ethnicity, gender, culture or ability)? What do you think shaped those attitudes and beliefs? (Horrill et al., 2021)
- How can you establish trust and collaboration with the families to whom you provide care? How can you share power with the families with whom you work? (Horrill et al., 2021)
- What do you do when you witness racism at work? In the community? In your personal interactions? (Clarke, n.d.; Horrill et al., 2021)
- What does cultural safety mean to you?
- How do you identify and incorporate the strengths of the families you work with into your interactions with them? (Horrill et al., 2021)
- How do you identify structural barriers experienced by the families with whom you work? How do you work to address them? (Horrill et al., 2021)

Appendix C

Semi-Structured Interview Guides

Initial Interview

What is the story of your understanding of, and engagement with Indigenous cultural safety in your practice?

Allow the OT to share their story. Use follow-up questions and/or prompts below to explore the aspects of the OT's journey to culturally safer care.

Prompt participants to talk about the following areas as needed:

Understanding of cultural safety, learning thus far

- Understanding or definition of cultural safety
- How they learnt about ICS
- Participation in any training/ workshops
- Self-directed learning (Personal reading/ discussions/ soc media/ active engagement)
- Motivation to join Community of Practice (CoP)

Practice approaches when engaging with individuals and families of another culture, background, or group

- Approaches when engaging with Indigenous families in practice
- Challenges or successes
- How they establish trust and collaboration
- Reflection on power dynamics in clinical interactions

Learning needs for the CoP

- Perceived strengths
- Learning needs, goals related to ICS
- Learning needs/ goals for this CoP

Final Interview

What is the story of your understanding of, and engagement with Indigenous cultural safety in your practice? Has your participation in the CoP changed this story? If yes, how so?

Allow the OT to share their story. Use follow-up questions and/or prompts below to explore the aspects of the OT's journey to culturally safer care.

Prompt participants to talk about the following areas as needed:

Changes as a result of participation CoP

- Understanding of cultural safety
  - How has your understanding of CS changed or been reinforced by the CoP?
- Changes in attitudes, beliefs, thinking.
  - Tell me about your growth/ development through the CoP.
- Practice of reflexivity about power, privilege, positionality
  - Has the CoP influenced you r perception of your positionality, social location?
- Changes to approaches to individuals and families receiving care

- Challenges in implementing change
- Successes experienced

Perception of effectiveness of CoP format for ICST

- What aspects of CoP were most influential?
- Suggestions for changes to format or content
- Would you recommend it to other rehab therapists? Why/why not?

Appendix D

HREB Ethics Approval

Research Ethics Bannatyne
P126-770 Bannatyne Avenue
Winnipeg, MB R3E 0W3
T: 204 789 3255
F: 204 789 3414
bannreb@umanitoba.ca

University of Manitoba | Research Ethics and Compliance

HEALTH RESEARCH ETHICS BOARD (HREB)
CERTIFICATE OF FINAL APPROVAL FOR NEW STUDIES
Delegated Review

PRINCIPAL INVESTIGATOR:	INSTITUTION/DEPARTMENT:	ETHICS #:
Christine Froese	University of Manitoba/College of Medical Rehabilitation Sciences-Occupational Therapy	HS26023 (H2023:175)
APPROVAL DATE: June 20, 2023	**EXPIRY DATE:** June 20, 2024	
STUDENT PRINCIPAL INVESTIGATOR SUPERVISOR (If applicable): Dr. Cara Brown		

PROTOCOL NUMBER:	PROJECT OR PROTOCOL TITLE:
	Pediatric Occupational Therapists' Journeys Towards Culturally Safer Care Through Participation in a Community of Practice: A Qualitative Study
SPONSORING AGENCIES AND/OR COORDINATING GROUPS: University of Manitoba	

Submission Date of Investigator Documents:	HREB Receipt Date of Documents:
May 31, 2023 and June 15, 2023	May 31, 2023 and June 15, 2023

THE FOLLOWING ARE APPROVED FOR USE:

Document Name	Version (if applicable)	Date
Protocol:		
Revised protocol along with proposal as outlined in the revised University of Manitoba Bannatyne Campus Research Ethics Board Submission Form and Letter of Response dated June 15, 2023		June 14, 2023
Consent and Assent Form(s):		
RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM Individual Interview and Sharing Sessions	V. 2	June 14, 2023
Other:		
Questionnaires/Instruments Appendix		May 26, 2023
Advertisements/Recruitment/Social Media Appendix		May 26, 2023
Participant Contact Information Master List		May 23, 2023
Participant Screening Telephone Questionnaire		May 27, 2023

CERTIFICATION
The above-named research study/project has been reviewed in a ***delegated manner*** by the University of Manitoba (UM) Health Research Board (HREB) and was found to be acceptable on ethical grounds for research involving human participants. The study/project and documents listed above was granted final approval by the Chair or Acting Chair, UM HREB.

HREB ATTESTATION
The University of Manitoba (UM) Research Board (HREB) is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement 2, and the applicable laws and regulations of Manitoba. In respect to clinical trials, the HREB complies with the membership requirements for Research Ethics Boards defined in Division 5 of the Food and Drug Regulations of Canada and carries out its functions in a manner consistent with Good Clinical Practices.

Appendix E

Recruitment Materials

Social Media Posts

The following social media posts were shared on Instagram, Facebook, Twitter and LinkedIn. Social media post #1 was also posted on the Manitoba Society of Occupational Therapists (MSOT) website in the research recruitment section.



Figure 3: Recruitment Material- Social Media Post #1



Figure 4: Recruitment Material- Social Media Post #2

Recruitment Email

Dear Occupational Therapist,

My name is Chris Froese. I am a Master of Science student in the College of Rehabilitation Science (CoRS) at the University of Manitoba and an occupational therapist working in pediatrics. I am conducting a research project called **"Pediatric Occupational Therapists' Journeys Towards Culturally Safer Care Through Participation in a Community of Practice: A Qualitative Study"** under the supervision of Dr. Cara Brown.

The aim of this study is to explore the impact of participation in a cultural safety community of practice (CoP) on the practices of pediatric occupational therapists who work in an urban setting.

We invite you to participate if you are an English-speaking occupational therapist in the Winnipeg area, who works with children at least two days per week and would like to participate in a six-session community of practice focusing on Indigenous cultural safety. You are eligible to participate in this study if you answer **YES** to the following questions:

1. Are you a practicing occupational therapist who works a minimum of 2 days per week with children?
2. Have you been in your current position for at least 3 months?
3. Do you have Indigenous children on your caseload?
4. Are you interested in learning more about Indigenous cultural safety?

Your participation would involve:

- attending six (6) in-person, 90-minute community of practice (CoP) sessions between August and November 2023,
- completing reflexive journaling between the CoP sessions, and
- participating in two interviews (60-90 minutes each), one prior to the CoP series and one after the CoP series has concluded.

You will also have the opportunity to contribute to the CoP content, should you wish to do so.

If you know of anyone who may be interested in participating in this study and may fit the eligibility criteria, please forward this invitation to them.

If you would be interested in participating or if you have questions about this study, please do not hesitate to contact the principal investigator, **Chris Froese at** [redacted]

Thank you for your consideration!

Chris Froese

Appendix F

Participant Screening Telephone Questionnaire

In this study you will be asked to participate in a community of practice (CoP) focusing on Indigenous cultural safety. The CoP will consist of six, 90-minute sessions, 3 weeks apart. The sessions will take place in Winnipeg at the University of Manitoba Bannatyne campus on Monday or Wednesday evenings.
Curriculum for the CoP will be co-developed by myself, a co-facilitator from the Centre for Healthcare Innovation, and the participants. I will provide you with an outline of topics that will be covered after the initial interview. All participants in the CoP are encouraged to share resources and learning activities related to the topics planned, however, you are not required to provide resources or materials in order to participate in the CoP.
You will also be asked to participate in two, 60–90-minute interviews about your journey towards cultural safety in your OT practice. One will take place before the CoP series and the final interview will take place after the completing of the CoP interview. The interview can take place at a private location of your choosing (your office, home or at an office at the University of Manitoba, Bannatyne campus).

Study participant eligibility questions:
Inclusion (must answer yes to each question):

1. Are you a practicing occupational therapist?
2. Do you work a minimum of 2 days per week with children?
3. Have you been in your current position for at least 3 months?
4. Are approximately 15% of the children on your caseload Indigenous?
5. Are you willing to participate in six in-person community of practice sessions In Winnipeg on weekday evenings from July to December?
6. Are you willing to complete reflective journaling between the CoP sessions (these journal entries are for your own reflection)?
7. Are you willing to participate in two, 60-90 minute interviews with me?

Exclusion (excluded if answer is yes):

1. Have you worked exclusively in an Indigenous community for a period of 1 year or more?

If we have more volunteers than needed, participants will be chosen to maximize diversity of participant group. The following questions will be used to help determine which participants are invited to the community of practice in the event we have more volunteers than CoP spaces.

Study participant diversity questions (you may choose to withhold any answers in this section);

1. How many years have you practiced as an occupational therapist? _____
2. What is your gender identity? _____
3. What is your race? (List all that apply: Indigenous, Black, Person of Colour, White/ Caucasian, other)

Thank you for your time. I will email you the research participant information and consent form to review. If you are interested in participating in the study, please reply to me by email so we can arrange an interview date and time. I will answer any other questions have at that time and ask you to sign the participant consent form.

Appendix G

Research Participant Information and Consent Form

Pediatric Occupational Therapists' Journeys Towards Culturally Safer Care Through Participation in a Community of Practice: A Qualitative Study

College of Rehabilitation Sciences
R106 - 771 McDermot Avenue
Winnipeg, Manitoba
Canada R3E 0T6
T: 204 789 3897
F: 204 789 3927
CORS.info@umanitoba.ca

University of Manitoba | Rady Faculty of Health Sciences

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM
Individual Interview and Sharing Sessions

Thank you for your interest in participating in this study.

Title of Study: Pediatric Occupational Therapists' Journeys Towards Culturally Safer Care Through Participation in a Community of Practice: A Qualitative Study

Principal Investigator:
Chris Froese
R106-771 McDermot Avenue
Winnipeg, Manitoba R3E 0T6
[redacted]

Co-Investigator:
Dr. Cara Brown
R106-771 McDermot Avenue
Winnipeg, Manitoba R3E 0T6
([redacted]

Co-Investigators:
Dr. Jacquie Ripat
R215-771 McDermot Avenue
Winnipeg, Manitoba R3E 0T6
[redacted]

Dr. Mary Wilson
1155 Notre Dame Avenue
Winnipeg, Manitoba R3E 3G1
[redacted]

Ogai Sherzoi
3rd floor, Chown Building
753 McDermot Avenue
Winnipeg, Manitoba R3E 0T6
[redacted]

Funder: College of Rehabilitation Sciences Endowment Fund and self-funded

You are being asked to participate in a research study which will involve participation in a six (6) session community of practice and two in-person interviews. Please take your time to review this consent form and discuss any questions you may have with the study staff before you make your decision. Please ask the study staff to explain any information that you do not clearly understand.

Pediatric Occupational Therapists' Journeys Towards Culturally Safer Care Through Participation in a Community of Practice: A Qualitative Study

Purpose of this Study

This research study is being conducted as part of the principal investigator's Masters of Science thesis project, to study better understand the learning journey occupational therapists take when trying to become culturally safer practitioners through a community of practice (CoP). You will be asked to engage in Indigenous cultural safety training including:

- critical self-reflection,
- exploration of your own stereotypes and biases,
- the impact of stereotypes and biases on Indigenous children and families
- historical and present-day traumas experienced by Indigenous populations,
- anti-racism activities and,
- reflection on how you could do better in your occupational therapy practice.

This study will also explore the extent to which the community of practice learning model was helpful for learning about Indigenous cultural safety.

Participants Selection

You are being asked to participate in this study because you have self-identified as an occupational therapist working with children in the Winnipeg area, who is interested in learning more about Indigenous cultural safety in your practice.

A total of 6-8 participants will be asked to participate in the cultural safety community of practice.

Study procedures

If you take part in this study, you will participate in the following steps:
Step 1: Initial Individual Interview.

- To learn about your understanding of Indigenous cultural safety, your past experiences and your learning goals for the community of practice.
- The interview will be conducted by the principal investigator, Chris Froese at the University of Manitoba in a private space, or in alternate location of your choosing (e.g., your office or home).
- The interview will be audio-recorded and transcribed by a professional transcription service and/or the Principal Investigator to ensure accurate documentation of the information you share.
- Transcribers will sign a form stating that they will not discuss any item on the tape with anyone other than the researchers.

Step 2: Participation in Community of Practice and Group Sharing Sessions.

- Six (6), 90-minute community of practice (CoP) sessions will take place approximately every 3 weeks between August and November 2023. There will be 6-8 other participants in the CoP, including the principal investigator, who will be both a participant and co-facilitator. The CoP sessions will be co-facilitated by the principal investigator and a trained facilitator, Ogai Sherzoi, from the Center for Healthcare Innovation. The CoP will have invited Indigenous Elders and/or Wisdom Keepers at some sessions to assist with the group's learning.
- At the first CoP session everyone will be asked to respect the privacy of the other group members. All participants will be asked not to disclose anything said within the context of the discussion, but it is important to understand that other people in the group with you may not keep all information private and confidential.

- You will be provided with an outline of the proposed curriculum after the initial interview. You are welcome, but not required, to suggest additional resources and activities for the CoP. We intend to develop the curriculum and learn together as a group. All resources shared by co-facilitators and participants will be posted to the Cultural Safety Community of Practice Team on the principal investigator's Microsoft Teams account. This team will only be accessible to CoP participants and study team members. You may choose to have resources emailed to you individually if you do not want to join the Cultural Safety Community of Practice Team.
- At the end of each session participants will be provided with a question for reflection (or the group may decide on a question together). Sample questions may include: What does cultural safety mean to you? What attitudes, values and beliefs do you hold about people that are different from you (e.g. ethnicity, gender, culture or ability)? What do you think shaped those attitudes and beliefs?
- You will be asked to journal your thoughts about the question in preparation for the sharing time at the beginning of the next community of practice session. You will not be asked to share your journal entries with anyone.
- Short (15-minute) group sharing sessions will be conducted at the beginning of each CoP. Sharing sessions are group discussions with the other members of the community of practice, reflecting on the topic of interest. These will be audio-recorded and used as data for the study, to help understand the learning process of the participants. The sharing sessions will be based on a question posed at the end of the previous CoP. The CoP co-facilitator, Ogai Sherzoi, will facilitate the discussion.
- Only the 15-minute sharing sessions will be audio-recorded. The recording will be transcribed by a transcription service and/or the principal investigator. If names are used during the sharing session that is audio-recorded, they will be removed and replaced with a pseudonym during the transcription process. You may choose your pseudonym today if you like.

Step 3: Final Individual Interview.

- This interview will again explore your understanding of Indigenous cultural safety. It will also explore what changes you have or have not made as a result of your participation in the CoP in order to understand your journey towards culturally safer care for Indigenous children and families. You will also be asked your opinion about the value of a CoP model to learn about Indigenous cultural safety.
- You may choose to review your journal entries before this final interview, but you are not required to do so, and you will not be asked to share the content of your journal entries.
- The interview will again be conducted by the principal investigator, Chris Froese at the University of Manitoba in a private space, or in alternate location of your choosing (e.g., your office or home).
- The interview will be audio-recorded and transcribed by a professional transcription service and/or principal investigator to ensure accurate documentation of the information you share.
- Transcribers will sign a form stating that they will not discuss any item on the tape with anyone other than the researchers.

Step 4: Analysis and sharing the stories.

- After all of the data has been gathered the research team (principal applicant and the advisory committee) will analyze the data for themes. These themes will be compared between participants and also within individual participant's stories.

- Once the themes and variations have been identified the principal investigator will write one or more stories reflecting the themes and variations of the CoP group.
- You will be given an opportunity to review these stories and provide feedback about their accuracy via email if you wish.

If you would like to receive the final study results, a copy of the principal applicant's thesis can be emailed to you upon submission to University of Manitoba MSpace.

During the study your data will be stored in the following ways:

- All data will be stored in password protected files on a University of Manitoba Microsoft Teams account belonging to the principal applicant. Teams is an externally hosted cloud-based service. A link to their privacy policy is available here https://www.microsoft.com/en-ca/trust-center/privacy. While the University of Manitoba Health Research Ethics Board has approved using the platform to collect data for this study, there is a small risk of a privacy breach for data collected on external servers.
- Audio recordings will be done using a digital voice recorder. Audio files will be uploaded to Microsoft Teams on the same day they are recorded and saved as password protected computer files until they have been transcribed.

After the study is completed (approximately June 2024), the audio files will be deleted and the remaining written data will be transferred to a password protected file on the R: Drive at the University of Manitoba for 5 years after the study has been concluded. Dr. Cara Brown will delete this file at that time.

Risks and Discomforts

There are some potential risks to you by participating in this research. It is possible that talking about Indigenous cultural safety and your learning journey might be emotional, embarrassing or stressful for you. The CoP co-facilitator, Ogai Sherzoi, is a professional facilitator with a background in social work and will be available to support the group members to work through these difficult feelings. If you feel like there is anything that has come up for you during the study period including the individual interviews, sharing sessions and/or the CoP sessions themselves that is upsetting, a resource list of free and low-cost resources is available from the co-facilitators. This resource list will be available at each CoP session and can be provided between sessions via email. Should you choose a low-cost counselling option, you will be responsible for the fee. There is no additional funding available through the study.

Benefits

Being a member of the community of practice may or may not help you directly. The information gained from this study may inform continuing Indigenous cultural safety training approaches in the future. Possible personal benefits of participation include:

- the learning opportunity provided by participation in the CoP (both professionally and personally),
- a potential sense of satisfaction at your personal growth through the CoP process,
- you may gain skills as a clinician to practice in a more culturally safe way, and
- you may be able to use your participation in the CoP as an activity in your professional development plan required by the regulatory college.

Pediatric Occupational Therapists' Journeys Towards Culturally Safer Care Through Participation in a Community of Practice: A Qualitative Study

Costs
There is no cost to you to attend the community of practice session, however you may need to pay for parking while attending the interviews and CoP sessions.

Payment for participation
You will be given a $35.00 e-gift at the time of your initial interview. You **will not** be required to return this gift card if you withdraw from the study.

Confidentiality
We will do everything possible to keep your personal information confidential if that is what you wish. A list of names and contact information of participants will be kept in a secure file so we can send you information about the CoP sessions and a summary of the results of the study. A pseudonym will be used on all other study forms and documents unless you indicate that you would like your real name used. If the results of this study are presented in a meeting, or published, nobody will be able to tell that you were in the study, unless you tell me that you would like your real name used in publications (see "Permission to Quote"). Please note that although you will not be identified as the speaker, your words may be used to highlight a specific point. The collection and access to personal information will be in compliance with provincial and federal privacy legislations.

During the CoP sessions we ask that all participants respect and maintain the confidentially of the discussion; however, it is not possible for the researchers to guarantee that everyone will do so.

Audiotapes of the interviews and CoP sharing sessions will be deleted after the data analysis has been completed and the thesis has been submitted (approximately June 2024).The typed transcripts will be kept for five (5) years in a password protected file on a University of Manitoba server. Only the research staff will have access to them.

Some people or groups may need to check the study records to make sure all the information is correct. All of these people have a professional responsibility to protect your privacy.

These people or groups are:

- The Health Research Ethics Board of the University of Manitoba which is responsible for the protection of people in research and has reviewed this study for ethical acceptability, and
- Quality assurance staff of the University of who ensure the study is being conducted properly.

Written transcripts of your interview and the CoP group sharing sessions will be password protected and stored on a University of Manitoba Microsoft Teams account in a private team accessible only to study staff. The audio recordings of the interviews will be shared only with the transcription service and will be transmitted using password protected files.

Permission to Quote:
We may wish to quote your words directly in reports and publications resulting from this. With regards to being quoted, please check yes or no for each of the following statements:

Pediatric Occupational Therapists' Journeys Towards Culturally Safer Care Through Participation in a Community of Practice: A Qualitative Study

Researchers may publish documents that contain quotations by me under the following conditions:	
☐ Yes ☐ No	I agree to be quoted directly (my name is used).
☐ Yes ☐ No	I agree to be quoted directly if a made-up name (pseudonym) is used.

Voluntary Participation/Withdrawal from the Study

Your decision to take part in this study is voluntary. You may refuse to participate, or you may withdraw from the study at any time.

If you work with the principal applicant, Chris Froese (at the Rehabilitation Centre for Children), your participation or discontinuance in the study will not constitute an element of your job performance or evaluation nor will it be part of your personnel record at any of these Institutions.

Questions

If any questions come up during or after the study contact the principal investigator and the study staff:
Chris Froese at [redacted] or [redacted]
Dr. Cara Brown at [redacted] or [redacted]

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at 204-789-3389

Consent Signatures:

1. I have read all seven (7) pages of the consent form.
2. I have had a chance to ask questions and have received satisfactory answers to all of my questions.
3. I understand that by signing this consent form I have not waived any of my legal rights as a participant in this study.
4. I understand that my records, which may include identifying information, may be reviewed by the research staff working with the Principal Investigator and the agencies and organizations listed in the Confidentiality section of this document.
5. I understand that I may withdraw from the study at any time and my data may be withdrawn prior to publication.
6. I understand I will be provided with a copy of the consent form for my records.
7. I agree to participate in the study.

Participant signature _____ **Date** _____
(day/month/year)

Participant printed name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

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Printed Name: _____ **Date_____**
(day/month/year)

Signature: _____

Role in the study: _____

Relationship (if any) to study team member: _____