

STORIES OF PEDIATRIC REHABILITATION PRACTITIONERS

WITH/IN INDIGENOUS COMMUNITIES



A GUIDE TO BECOMING CULTURALLY SAFER

PRESENTED IN COLLABORATION WITH



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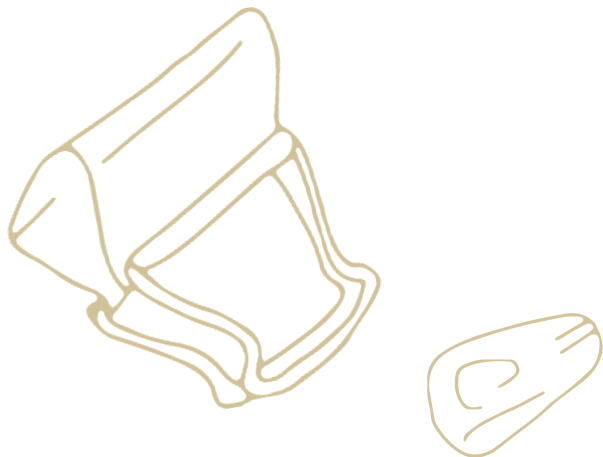
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This guide was developed by an interdisciplinary team working at McGill University, which is situated on the unceded territory of the Kanien'kehà:ka, and in partnership with members of the Eeyou Istchee Territory. We express gratitude towards the Kanien'kehà:ka (Mohawks) for being able to live among these lands and waters. In recognition of the ongoing impacts of colonialism perpetrated toward Indigenous peoples by Canada, this research team studied well-beyond the bounds of this project, and endeavored to learn, and follow, the ethics of anti-colonial research.





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PREFACE

This project was conducted as a professional master's occupational therapy research project under the supervision of Hiba Zafran. The five research students selected to participate in this project from their own interests, intentions, and values.

COMMUNITY PARTNERS

JESSICA JACKSON-CLEMENT is a Cree, Algonquin, and French Québécois woman and an experienced social worker in the Eeyou Istchee territory. In October 2019, she took on her role as Coordinator for the Disability Programs Specialized Services where the Cree Neurodevelopmental Diagnostic Clinic (CNDC) is housed. This is the first time that the CNDC has Indigenous leadership. The partnership between Jessica and Hiba, which lead to this research project, first began two years ago, as part of Hiba's desire to contribute academic resources towards Indigenous communities.

AIMEE-ELIZABETH PARSONS is a settler of British origins, and an educator who began her teaching career in a Northern community. She joined the CNDC team in 2019 to support program development and research initiatives. Jessica and Aimee delineated this project's aims and desired deliverables based on Cree community members feedback and the CNDC team members' questioning and concerns.

THE RESEARCH TEAM

ALEXA CIRILLO is a settler Canadian of Italian and Filipina descent living in Tiohtià:ke (Montréal).

HILARY BYRNE is a settler Canadian originally from Wolastoqey territory that is now known as Fredericton, New Brunswick. She lives in Tiohtià:ke (Montréal).

WILLIAM MURPHY-GELDERMAN is a settler Canadian of Dutch descent who grew up on traditional Plains Cree land in Treaty 6 territory. He lives in Tiohtià:ke (Montréal).

DAISY PETRUCCI is a settler Canadian residing in Northern British Columbia. She lives on Treaty 8 First Nations lands.

NAOMIE GAMONDELE immigrated to Tiohtià:ke seven years ago from France. She is of Hungarian and Congolese descent. She lives in Tiohtià:ke (Montréal).

HIBA ZAFRAN is a multiple migrant following postcolonial tensions and present-day geopolitics. Her ancestral roots lie in the Levantine region of Syria-Lebanon-Palestine-Israel. She lives on territory cared for by the Haudenosaunee Confederacy.

About the main image that informed the style of this document: the primary elements include leather scraps, seeds (corn, squash, beans), wild rice, sinew with shell beads, scissors, a pen, the frond of an eastern cedar, and abstract-organic shapes. The idea is to reference “building”, but also the way that a single snapshot cannot always clearly show whether something is being built, or re-built, or destroyed. Much like a still frame, when we assess ourselves or someone else in a single moment, we are drawing conclusions without a story, contextless. The image is also anonymous, for the same reasons. These ideas are represented by the arrangement of static shapes caught in a moment of potential movement, by the presence of tools we use to make and build (scissors, pen), of materials (sinew, beads, leather), and of the products of creation (the beaded string). It further references life in pause (a hewn frond), life waiting to begin (dried seeds), and life in progress (cooked wild rice). It also places the industrial (plastic, metal) next to the organic (trees, seeds, shell, leather), referencing the “two worlds” inherent in two-eyed seeing; by bringing these ideas together in an act that is possibly productive or destructive, it is meant to signify the power of those two elements in concert. In a more concrete way, simply having objects that represent an industrial, mass-produced, colonial idea of productivity contrasted by something that may signify productivity in Indigenous cultures (past and present) such as beading or gathering is an interesting tension, forcing us to consider whether these objects hold different values to us, and why. Self reflection, a key concept in this project, therefore begins on the very first page, with the very first step into these carefully arranged data.

The major ideas captured on page one thus mirror significant themes from this written work: tension, harmony, familiarity, uncertainty, stages of growth and development, all caught in one moment, anonymously intertwined in the story of making or, possibly, unmaking. The potential violence of the images and their orientation in space, contrasted with the soft colours and organic lines, further obscures a single meaning. Therefore, the final interpretation, of course, is based on an individual’s experiences, perceptions, biases, and personal context, much like the journey readers will take when reading this work.

KÁH ENTI:NE MARCY MARACLE grew up in Tyendinaga Mohawk Territory, a rural reservation in Ontario. She is a member of the Wolf Clan, and has been making art for most of her life, initially to pass the time in the lonely boredom of cultural isolation in the early 1990s, a period before the renewed social push to address Canada’s history of Indigenous genocide and systemic racism. Since then, developing skills to assist cultural and scientific organizations share knowledge and present ideas through visual representation has been a major driver for her freelance work, which she has been undertaking for 15+ years. As part of her curiosity, and desire to support different learning styles, she has taken on a range of projects, which include painting murals, designing buildings, creating websites, programming video games, and of course extensive graphic design work and branding for restaurants, universities, cities, individuals, and scientific organizations. She has had creative writing published, memoir excerpts, as well as several scientific illustrations. Her favourite projects on which to work are those that seek to share knowledge, research, and promote social engagement, in any form. She also enjoys editing written works, both creative and academic.

To consider the academic journey in Káh Enti:ne’s life, it is important to her to note that her credentials have been pursued with uncertain self-guidance and obligate perseverance, and an adult diagnosis of a learning difference. She has completed a BSc. at McGill University in ecological determinants of health with a minor in interdisciplinary life sciences, and undertook two years at OCAD University, initially in graphic design, and then later in new media and video game design. Most recently, she has been studying medicine at Schulich School of Medicine in London, Ontario. She is currently completing her fourth and final year of medical school, and hopes to follow her love of creating and learning and educating through a surgical residency program in the upcoming years.

Káh Enti:ne is happy to learn about any projects with which readers may require assistance or consultation. She can be contacted through her website www.kahentine.com or via email at design@kahentine.com.

ABOUT THE GUIDE

WHAT IS THIS GUIDE ABOUT?

This guide is about exploring Cultural Safety in paediatric rehabilitation services with and within non-urban Indigenous communities in Canada. It is framed for the reality that many services are developed—and practitioners are situated—in the ongoing oppression of colonization and systemic racism. No matter how much ‘safer’ Western-educated healthcare and rehabilitation practitioners become, they currently continue to be part of inherently violent and inequitable structures.

WHO IS IT FOR?

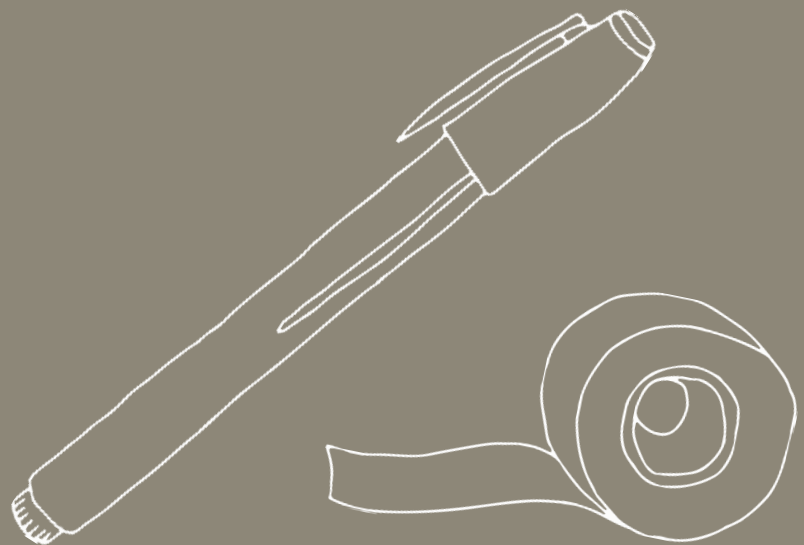
The majority of the consultants and researchers involved in this project are non-Indigenous; therefore, the stories and context of the guide reflect this perspective. In so doing, the intended audience of this guide is primarily non-Indigenous rehabilitation and healthcare practitioners, as well as Indigenous practitioners whose practices are shaped by Western-colonial academic institutions, who are working with Indigenous families and children in rural, isolated or northern settings. Indigenous community members and those working in urban or adult contexts will be interested to understand this perspective as well. This guide is not about systemic change in healthcare. Rather, we have the humbler intention of accompanying practitioners in the moral dilemmas of being part of oppressive systems. We share these stories with deep respect for those who are committed on this path, as reconciliation and decolonization have yet to become a reality in Canada.

HOW TO USE THIS GUIDE

The guide begins with why paediatric rehabilitation with Indigenous children has specific considerations and introduces you to many different concepts that intertwine with Cultural Safety, such as: positionality, social identity, and White Supremacy. We outline an Anti-Colonial Research approach and provide theoretical, practical, and experiential understandings of Cultural Safety specific to work with Indigenous children and families. Throughout the guide we will use the term ‘practitioner’ for all consultants, defined here as one who practices with and for Indigenous children and families. The guide follows the stories of practitioners as they reflect on their experiences within Indigenous communities, and what Culture Safety means to them. Included are an extensive reference list, appendices of resources, and a reflective workbook.

THE POWER OF STORIES & OUR HOPES FOR THIS GUIDE

Stories are central to this guide. As it progresses, the writing becomes more narrative than scientific to honour the power of collective knowledge through storytelling. The stories people share, and how they share them, can illuminate ethical dilemmas, and guide us towards co-creating relationships and practices that allow for a more viable life. ^[1, 2] Our intention is not to prescribe exact steps to achieve culturally safety, or what it should look like, but to illustrate the complexity of becoming culturally safer by providing guideposts. For each guidepost, we have collaged the stories of consultants together and included ourselves in the text, ^[3] weaving wisdom together with respect for (re)storying as a way of seeing anew where hope lies. ^[4-6]



THE CONSULTING PRACTITIONERS

LISA ARCOBELLI is a white second-generation Canadian physiotherapist with 14 years of clinical experience in a variety of settings including acute and out-patient care, stroke and paediatric rehabilitation, and community-based rehabilitation in northern Indigenous communities in Canada. She is currently completing a Masters in Rehabilitation Science at McGill University where her research explores how Canadian physiotherapy curricula are changing in relation to Indigenous Peoples. She is on the Executive Committee of the Global Health Division (GHD) of the Canadian Physiotherapy Association and is a member of the GHD's Indigenous Health Subcommittee.

MYRIAM BERNIER is a speech-language pathologist who has been working in Northern Ontario for over 4 years. Through her work at FIREFLY, Myriam has provided support and services to families as well as their community. Providing culturally safe services has been a personal objective for Myriam since her first day of work at FIREFLY.

Elder DEBBIE CIELEN "GOOD TALKING TURTLE" is an Indigenous woman from Winnipeg, Manitoba. Elder Debbie has been involved in cultural teachings and ceremonial practices for over 30 years. Elder Debbie has had the honour and privilege to provide land-based cultural safe teachings for the children enrolled in the Winnipeg Stepping Out on Saturday (SOS) Chickadee program offered through the Rehabilitation Centre for Children located in Winnipeg, MB. Debbie is the Elder-in Residence at Miikana Pimatiziwin.

CAITLYN DEBRUYNE is a practicing Occupational Therapist and co-founder of Northern Therapy Services. She has spent her whole career specializing in providing services in rural and remote areas of Northern Canada and International settings. She is a strong advocate for the importance of providing culturally safe care and empowering communities and people in their health journeys.

MOLLY FLINDALL-HANNA is an occupational therapist passionate about advocating for diversity and inclusion. This career path has taken her to Tanzania for international community development, Northern Alberta for rural work in school health, and now to Vancouver, British Columbia, supporting Indigenous families with early intervention. Molly enjoys learning from those with the lived experience, and traveling to gain insight about different communities and cultures.

STEPHANIE GARRETT is an occupational therapist who was raised and educated in Southern Ontario. She moved to Northern Ontario in 2017 and currently resides in Sioux Lookout and works for FIREFLY. This organization provides local services and is contracted by First Nations organizations to provide a variety of rehabilitation services to reservations. A large part of her job involves driving or flying to provide services to children that reside on First Nations that are part of the Nishnawbe Aski Nation.

MYLÈNE HACHÉ is a physiotherapist with 12 years of experience working with the Cree Nations of the Eeyou Istchee. She has worked with a wide variety of clientele in various clinical settings throughout her career. She is passionate about her patients, project development, and improving service efficiency in health care.

JANNA MACLACHLAN OT Reg. (Ont.), is a PhD Candidate in the Social and Behavioural Health Sciences Division of the Dalla Lana School of Public Health Sciences at the University of Toronto. She has worked as an occupational therapist in Nunavut since 2006, currently providing school-based services to four schools in the Qikiqtani Region. From her position as a white woman of settler ancestry, Janna is examining, in her doctoral dissertation work, how rehabilitation services can decolonize and ensure space and respect for Inuit knowledge.

ANGIE PHENIX MOT, M.Ed is a mother, Métis woman, scholar, educator, and occupational therapist. She has spent most of her career working in rural, remote, and often Northern regions of Canada, across both health and education. She is co-chair of both the Canadian Association of Occupational Therapists' *Occupational Therapy and Indigenous Health Network* and its Truth and Reconciliation Commission's Taskforce. Since the beginning of her career, Angie noticed the tension and problematic nature of using a Western-based model of practice in Indigenous communities. As an attempt to put words to these feelings, better address health and educational inequities, and become a better OT, she pursued a Masters of Indigenous Education at the University of Saskatchewan. Her life, education, and career experiences have helped to identify a lens to critically analyze how political, social, moral, historical, and economic structures co-exist to create different realities for those who live on these lands, creating privilege/empowerment or oppression/disadvantage dichotomies. Angie has (co)authored several publications and led many presentations with the aim of shedding a critical light on the occupational therapy profession.

STACIE RIVARD grew up in Winnipeg, Manitoba where she studied biological and cultural anthropology at the University of Winnipeg. She started learning more about Indigenous culture and medicine and graduated from university of Manitoba with a master's in Occupational Therapy. Stacie now works in Yellowknife in the Northwest Territories providing paediatric occupational therapy in Yellowknife and to the smaller communities across the Northwest Territories and Nunavut.

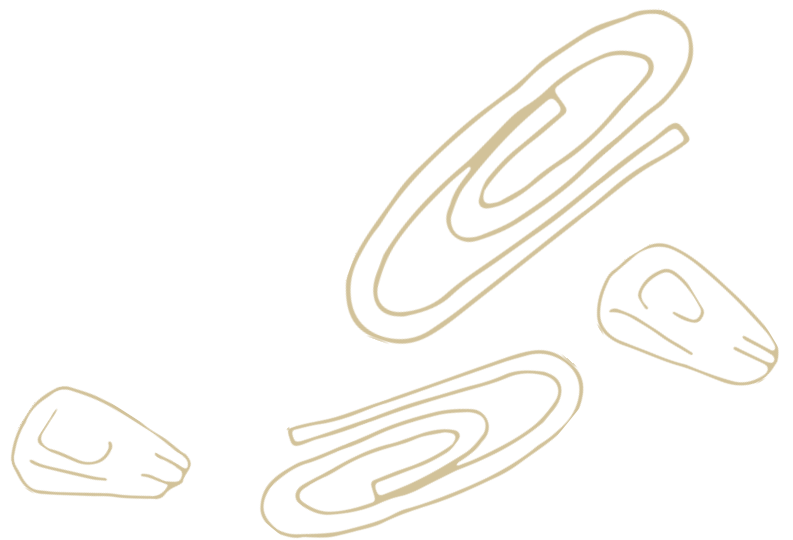
ELA RUTKOWSKI is an Occupational Therapist.

OKA SANERIVI is a Senior Paediatric Physiotherapist of Samoan and Tongan heritage who is practicing in Aotearoa, New Zealand. He works among Maori communities in Turanga-nui-o-Kiwa on the East Coast of the North Island. He is currently working towards a research master's focussed on culturally responsive Physiotherapy approaches to working with Pacific children in Aotearoa, New Zealand. He is also the acting Chair of the Pasifika Physiotherapists Association.

MARGRÉT THOMAS is a physiotherapist from Manitoba. She is based in Winnipeg, and coordinates and works in the First Nations Physiotherapy Program provided by Community Therapy Services of Manitoba Inc. She travels to six isolated Indigenous communities using small airlines, and one community by road access, to provide rehabilitation services on a regular basis. The purpose of the program is to provide rehabilitation care that would otherwise be available only by leaving the community, or might not be considered at all, for the patients. Her responsibilities include educational time with other staff or community members. It is a professionally challenging job which provides a lot of personal satisfactions.

REBECCA WURM is a paediatric occupational therapist working on St. Mary's First Nation in New Brunswick. Although American by birth, she has been happy to call Canada her home for eight years. Rebecca has found her work with First Nation children and families to be the most meaningful in her 16-year career.

There are three consultants who chose to remain anonymous.
We respect their decision and honour their contributions equally.



EXECUTIVE SUMMARY

BACKGROUND Indigenous peoples receive lower quality healthcare services than non-Indigenous peoples within a demonstrated context of systemic racism. This is compounded in paediatric services with the colonial imperative to assimilate and remove Indigenous children from their communities and cultures. Despite increasing recognition of the principles and importance of implementing Cultural Safety, there exists a lack of illustrative research on the tensions and skills in actually practicing cultural safety within specific Indigenous communities and contexts. The aim of this project was proposed by, and developed in partnership with, the Cree Neurodevelopmental Diagnostic Clinic in Québec.

PURPOSE Explore culturally safe rehabilitation practices around neurodevelopmental diagnoses in children and their families, within rural or remote Indigenous communities.

METHODS This project relied on an anti-colonial research framework. Eighteen definitions of cultural safety were extracted from the literature and thematically analyzed for core elements. Narrative interviews (n=17) were conducted with practitioners, administrators, and Elders working in and around rehabilitation in isolated Indigenous communities. Their perspectives on cultural safety in practice were compared to the literature. Their stories were narratively interpreted and represented in order to engage the reader in understanding the particularities and stakes in practitioner experiences of becoming culturally safer.

FINDINGS Definitions of cultural safety in the literature include four common recurring elements: (1) reflexive practice relating to one's social characteristics, (2) power dynamics within a sociopolitical-historical context, (3) safety as defined by the patient, and (4) patient self-determination. While overlapping with practitioners' perspectives, the consultants explicitly named trauma-informed approaches and the complexity of relationship building. More deeply, practitioners experience cultural safety as an on-going journey to becoming a part of the communities they work with and in. This journey begins with embarking on an adventure, becoming and remaining unsettled, building community relationships, uncovering reconciliatory practices, and committing to staying on the journey with/in the communities.

CONCLUSION This guide focuses on the experiences of primarily settler rehabilitation professionals. The engagement of the consultants demonstrates the need for further exploration of how safer practices come to be understood and embodied across various healthcare contexts and Indigenous communities, and what kinds of languages or frameworks, educational preparation, and organizational supports are helpful. Their stories critically question and resist the use of standardized paediatric assessments within Indigenous communities, ideological assumptions of Eurocentric evidence-based practices, and Western notions of 'professionalism.'

INTRODUCTION

Canada has a history of perpetuating oppression and medical violence against Indigenous peoples, which continues to this day. Colonization has intentionally created systems that cause negative health and social consequences for Indigenous peoples.^[7] This complex history includes the physical genocide caused by diseases brought over from the colonizing countries, the negative implications of relocation to reserves, not honoring treaty rights for education and health, the assimilation and removal of children as a cultural genocide, and much more.^[8, 9] Although the public healthcare system of Canada is meant to provide equal healthcare to all citizens, testimonials have revealed the damaging history of governmental healthcare for Indigenous peoples in Canada, and the ongoing decreased access to services, poorer services, and worse or fatal outcomes in general when compared to the rest of the population.^[8, 10, 11] Research and truth-telling about this structural violence remains biased and incomplete in Western healthcare.^[7, 12, 13]

With regards to Indigenous child healthcare and rehabilitation, health care professionals in Canada have been involved in the practice of apprehending Indigenous children from their families and placing them in environments separate from their families, communities, cultures and traditions for over a century.^[14] Healthcare professionals such as doctors, nurses, and rehabilitation therapists were variously involved in experimentation on children, abuse, neglect, and racial violence with brutal consequences.^[15] This occurred in residential schools and Indian day hospitals, followed by the “sixties scoop,” and continues with the overrepresentation of Indigenous children in foster care across Canada.^[14] According to a census done in 2016, 52.2% of children in foster care are Indigenous even though Indigenous children constitute 7.7% of all children in Canada under the age of 14.^[16] This is known as the “millennial scoop.”^[17] There is, and should be, deep mistrust^[17] by Indigenous families towards health care professionals and systems.

One of the mandates that arose from the Truth and Reconciliation Commission of Canada (TRC) was to bridge and heal these systemic gaps in healthcare provision.^[18] The TRC was established in 2008 following the settlement of the Indian Residential School Settlement Agreement (IRSSA),^[19] to explore and reveal the history of collective harm of residential schools in Canada, while honoring the resilience of those affected.^[18, 19] In 2015, the TRC released 94 Calls to Action, many of which focused on Indigenous peoples’ rights to self-determination, including health.^[20] In particular, the health-focused actions called upon the government of Canada to recognize the value of Indigenous health practices, provide sustainable funding for the establishment of Indigenous healing centres, educate those in healthcare professions on Indigenous health issues, and increase the number of Indigenous healthcare professionals.^[20]

Unfortunately, as 2020 comes to a close, none of the seven health-related Calls to Action (18-24) are implemented in satisfactory or effective ways. ^[20, 21] As one of only four countries to initially vote against, and then be one of the last countries to sign, the United Nations Declaration on the Rights of Indigenous Peoples, ^[22, 23] Canada still has a long way to go to honor the treaties as well as the TRC, and in doing so, honor the rights and needs of Indigenous peoples.

Cultural Safety is a healthcare practice concept that arose within the context of these histories and issues. The term 'Cultural Safety' was developed in the 1980s by New Zealand Maori nurse Irihapeti Ramsden, in response to the Indigenous Maori peoples' discontent with nursing care and poorer health status of the Maori people. ^[24-26] She capitalized the term to indicate its specificity to settler-colonial conditions. Cultural safety has gained widespread use to refer to practices that acknowledge differential cultural and power dynamics between healthcare providers and service users in a multicultural and globalized world. The relevance of cultural safety principles for work with immigrant or racialized groups is not being contested. Rather, whether capitalized or not, in this guide, Cultural Safety is referred to within a settler-colonial reality and framework. ^[27]

Within medical and rehabilitation literature, there has been increasing recognition of the importance of Cultural Safety in providing effective services with and for Indigenous populations. Healthcare institutions, university programs, and national associations across Canada are exploring ways to respond to the Calls to Action of the TRC by implementing Cultural Safety within professional practice guidelines, position statements, healthcare institutional mandates, healthcare educational programs, and policies for care involving Indigenous peoples. ^[28-30]

Despite the importance of cultural safety in healthcare practice, current discourse typically focuses on defining cultural safety, examining colonial history in Canada, reporting statistics that highlight health disparities, delineating best practices based on values, and basic skills such as respect, reflection, and open communication. ^[31, 32] What successful cultural safety actually looks like in practice will vary between urban and rural/northern services, and across Indigenous communities whose histories, resources, and resiliencies are different. There is a gap between the ideals of Cultural Safety, and learning about local challenges to implementing culturally safer practices in specific clinical and community contexts. ^[33] This is certainly so around Indigenous children with presumed or diagnosed neurodevelopmental challenges, and their families in rural, isolated, or Northern communities. As one notable example, the use of standardized paediatric evaluation tools has been deemed an unsafe practice with Indigenous children due to incompatible norms and differential cultural activities, access, and historical trauma. ^[31, 34-37] There exists little practical guidance for Western-trained practitioners to engage in culturally safe paediatric rehabilitation practices within Indigenous communities in Canada. ^[28, 32] This project aimed to explore culturally safe rehabilitation practices surrounding neurodevelopmental diagnoses in children and their families, within remote Indigenous communities.

APPROACH: ANTI-COLONIAL RESEARCH

Researchers working with/in Indigenous communities are called to adhere to guidelines that can be quite different than traditional biomedical research ethics.^[38] An anti-colonial research framework was used to guide our approach. This framework begins by recognizing the long and ongoing history of colonization of Indigenous land and bodies by settler nations. Western science and research are deemed tools of colonization used to subjugate and discredit Indigenous ways of knowing.^[39] Anti-colonial research is about de-centering and questioning settler voices and norms, and re-centering Indigenous as well as oppositional ways of knowing.^[40] Researchers must engage in their research using critical reflexivity with specific attention to their positionality, and social identity.^[41]

The aim of such research should include the redistribution of power, knowledge, and resources within one's sphere of influence. We were able to meet some anti-colonial ethical principles by ensuring a partnership whereby the purpose of the project was defined by a Cree community partner, and where knowledge emerging from the project is made publicly accessible. Financial redistribution occurred by collaborating with a Mohawk artist and medical student—Marcy Maracle—for the design and final formatting of the guide. Anti-colonial research is not extractive, and therefore can name where the wisdom comes from (the stories). Because research consents stipulating anonymity were obtained for the interviews, the stories and quotes in this guide are de-identified with the use of pseudonyms for people, places, and organizations. However, the consultants were given the choice to be named and acknowledged herein. Those that agreed have provided their biographies.

DEFINING CULTURAL SAFETY IN THEORY VS PRACTICE

In order to better understand how cultural safety is defined and applied in paediatric rehabilitation within/for Indigenous communities, a review of the literature on cultural safety specific to work with Indigenous peoples was conducted with the support of a librarian. We did not limit our search to academic and peer-reviewed articles, as we know that cultural safety casts a much wider net; it cannot be defined solely by those from the academic world. Therefore, the review of cultural safety includes gray literature developed by Indigenous-led organizations. We also analyzed the consultants' definitions of cultural safety in order to better understand their practical views on the concept. The 18 definitions from the literature review, and those provided by the 17 consultants, were thematically analyzed and then compared.

EXPLORING THE EXPERIENCE OF BECOMING CULTURALLY SAFER

Consulting practitioners who are situated in different ways (e.g. Indigenous, non-Indigenous, clinician, administrator, etc.) were invited to share their experiences. Each has different knowledge, privileges and agendas with respect to Canada's oppressive history of Indigenous peoples, systemic racism in healthcare, and paediatric rehabilitation. Consultants engaged in narrative interviews that focused on the conversational sharing of stories (see Appendix 1). This approach allowed 17 consulting practitioners to return to their experience in order to describe what happened. ^[42] Stories highlight what matters most in relational encounters, as well as point to the structural elements and discourses that surround and impact experiences. ^[2] The stories that consultants shared with us illustrate the moral tensions, questions, and range of responses to implementing culturally safer practices within each of their contexts.

REPRESENTATION OF STORIES

The presentation and representation of other people's experiences happens through our own interpretive lens. We take responsibility for this creative license by including our own pronouns in here (us/we). In doing so, we are including the reader in our community of practice. We have collaged the stories of consultants together, ^[3, 43-45] while maintaining de-identification throughout with the use of the generic 'practitioner/clinician/therapist' and geographical pseudonyms (see Table 1). Some chapters are denser than others, and some themes repeat. We have purposefully kept this circularity and depth as a reflection of the experiences and narratives of the consultants, and the irreducible complexity and unfinished nature of the journey towards becoming culturally safer. Our intention is to engage the reader with a tricky and multi-perspectival story that provides guideposts for practice. Weaving the shared and hard-earned wisdoms of the consultants together is done with respect for (re)storying as a way of seeing anew where hope lies. ^[4-6]

TABLE 1

Geographical Pseudonyms

PSEUDONYM	DESCRIPTION
Kinnikinnik	Indigenous territory stretching into northern Canada.
Silverberry	Indigenous community in Kinnikinnik with a general hospital. It is a short drive from urban centres.
Willow	Far north fly-in community in Kinnikinnik.
Bearberry	Indigenous community with school-based rehabilitation in Kinnikinnik. It is accessible within a few hours by car from urban centres.
Northern Oak	Canadian town less than an hour drive away from Silverberry.
Maple	(Any) non-Indigenous urban city in Canada.

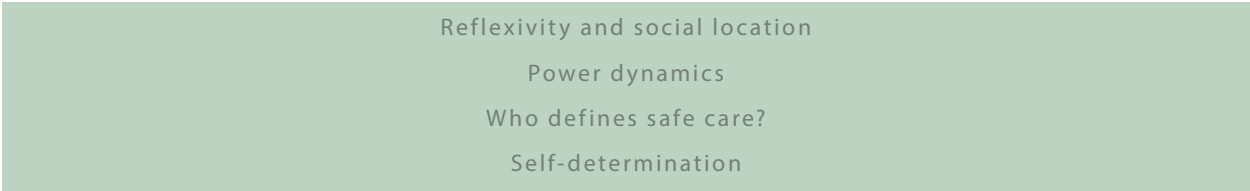
* We have chosen the names of northern Native American flora and trees to minimize the unintentional misuse of Indigenous terms.

DEFINING CULTURAL SAFETY IN THEORY VS PRACTICE

CULTURAL SAFETY IN THEORY & GUIDELINES

Cultural safety is a complex and emerging term. Eighteen definitions of cultural safety were thematically analyzed (see Appendix 2). We also explored how cultural safety might be evaluated as a process or outcome of healthcare.

Four elements were identified as core to the definitions of cultural safety:



Reflexivity and social location
Power dynamics
Who defines safe care?
Self-determination

REFLEXIVITY & SOCIAL LOCATION

Reflexive practice in cultural safety focuses on where we come from and how it impacts the care given. Social location is about where we identify ourselves, and are identifiable, in terms of our social characteristics and behaviors such as our stated profession, and perceived age, race, and gender. ^[46]

“Thus, cultural safety is concerned with both systemic and individual change with the aim of examining processes of identity formation and enhancing health workers’ awareness of their own identity and its impact on the care they provide to people from Indigenous cultural groups.” ^[47]

POWER DYNAMICS

Reflecting on one’s social location leads to a consideration of power imbalances beyond those that exist between a healthcare professional and any patient or family. These power dynamics are also about the broader context of widespread oppression, the specific colonial events within the community one is working in, and the systemic racism that continues to exist in healthcare.

“...cultural safety emphasizes recognizing the social, historical, political, and economic circumstances that create power differences and inequalities in health and the clinical encounter.”

^[48]

WHO DEFINES SAFE CARE?

Being culturally safe cannot be defined by the healthcare provider, but by the person receiving the care. This is a central tenet stated in Ramsden's original conceptualization of Cultural Safety:

"But it is not the nurse or midwife who determines the issue of safety. It is consumers or patients who decide whether they feel safe with the care that has been given." ^[26]

To our current knowledge, there are no specific tools or assessments to evaluate if one is engaging in a culturally safe practice, beyond having an open and trusting relationship where clinicians can validate their approach with the individuals accessing their services. Since safety is determined by the patient, each one has a unique perspective depending on their past experiences and on the context of the care.

"Cultural safety is a dynamic construct that can change depending on the community and context, and is ultimately determined by the patient and their family." ^[49]

SELF-DETERMINATION

Self-determination is located with the Indigenous person. It is the "the value that people have the right to choose and act in accordance with their own thoughts, needs, and feelings." ^[50] Some of the earlier work on cultural safety in New Zealand focused on respect of treaty rights, including self-determination. ^[51]

"Cultural safety is the effective nursing/midwifery practice of a person or family from another culture and is determined by that person or family... Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual." ^[52]

DEFINING CULTURAL SAFETY IN PRACTICE

During the interviews, the consultants were asked how they defined cultural safety, drawing from their experiences working around paediatric rehabilitation, in and with Indigenous communities.

Five common threads were identified in their definitions:

Power imbalance and White supremacy

Reflexivity on one's positionality

Trauma-informed practice

Relationship building

Empowerment of families

POWER IMBALANCE & WHITE SUPREMACY

Most of the practitioners are non-Indigenous professionals working in Indigenous communities (14 of the 17), and two of the Indigenous consultants work in communities that are not their Nation. Once they started working in Indigenous communities there was an acknowledgment of the existing power imbalance based on the view that Western culture—both personal and in terms of their professional training—is often viewed as the “main” culture versus the “other cultures.” This is White Supremacy, whereby white, western and European ideals and norms are considered the neutral and gold standard against which othered groups are evaluated and invariably come up short. ^[53] The practitioners went beyond social and historical differences in identity to name White Supremacy as an active and current process of oppression.

It's inherent in the language so when we talk about Cultural Safety, we're actually talking about White culture being the center and anything else around it being the quote unquote "culture" right?

Quotations and story threads collected from our interviews
with consultants are marked in sage.

REFLEXIVITY & (RE)POSITIONING

Understanding White Supremacy leads to both reflecting on one's positionality and re-positioning oneself with this increased awareness. Practitioners acknowledged their social location (e.g. age, gender, profession, settler), and the impact on practice. They also recognized that beyond categorizable identity, the worldviews, beliefs, and practices that are inherent in being situated in Western healthcare education promote racism. Western healthcare education is now openly acknowledged to be colonial and racist and requires critique and dismantling. ^[54] Furthermore, regardless of one's social location or educational background, one can intentionally reposition oneself in relation to their values, beliefs, and practices to engage in critical allyship for culturally safer care. ^[55, 56]

However you want to call it, but breaking apart our understanding of what our professional identity is to its constituent parts and simply owning those constitutions parts and saying, here I am as a whole person, which means that I'm White, that I'm female, that I'm whatever, all those things, but then I have these bag of tricks with a few things in them and so now I'm interacting with other people who have their own personal identity and their own skills and tricks.

TRAUMA-INFORMED PRACTICE

Acknowledging the existing power imbalance in the healthcare system as well as having a reflexive practice on their positionality helped shaped a trauma-informed practice. This consists of acknowledging and recognizing the ongoing sociopolitical-historical effects that are still affecting Indigenous communities, and acquiring relational and evidence-based practice skills and approaches that integrate this knowledge into everyday care. ^[57]

For Indigenous families, I see it being especially important given colonization and history of trauma and just the Western medicine versus their own cultural practices being at a clash sometimes. We're dealing with a lot of complexities and trauma in our communities.

RELATIONSHIP-BUILDING

The implications of the power-imbalance, the need to reposition oneself, and working in trauma-informed ways means that practitioners centered on building relationships within the communities.

I guess being culturally safe in that situation is understanding that that's a very legitimate response and recognizing that it's my job to earn trust and not assume that it can be given or that it should be given. I'm not owed trust just by virtue of being a practitioner that thinks they're doing a good job.

EMPOWERING FAMILIES

Empowerment places responsibility on the practitioner to facilitate “a social process of recognizing, promoting, and enhancing people’s abilities to meet their own needs, solve their own problems, and mobilize the necessary resources in order to feel in control of their own lives.”^[50] After earning patients’ and families’ trust, and recognizing families’ current needs, practitioners actively engaged families to empower them in decision making.

I always look at what the strengths of this family are, this community are, and just completely moving away from the deficit thinking because that is what guides tons of the media about First Nations. It’s deficits, and I think it’s time we change our messaging to strengths because there are many. It’s about making families feel like they’re strong, and they have the answers and you can walk beside them as they find out those answers and help them find their voice and advocate for them.

These five interwoven themes based on the consulting practitioners’ perspectives overlap with, but also extend and deepen the core elements found in the literature defining cultural safety (see Table 2). The intricate nature of developing and understanding cultural safety is reflected across time: the longer that practitioners had been working within the communities, the more they learned about their positionality and power imbalances, the better they were able to recognize and work with trauma, successfully build relationships, minimize harm, and empower families in trusting and respectful ways.

TABLE 2

Comparing Definitions of Cultural Safety in Literature vs Practice

CORE ELEMENTS	LITERATURE	PRACTICE
Reflexivity	Focused on social characteristics in formation of beliefs and behaviours.	Focused on both social characteristics and healthcare ideologies.
Power Imbalance	Related to the role of healthcare in colonization.	Related to colonization, white supremacy, and historical trauma.
Defined by Patients	Core to the original definition.	Implied in relationship-building.
Self-Determination Empowerment	Focus is on Indigenous right to self-determination.	Focus is on responsibility of provider to empower.
Trauma-Informed Practice	Implied in the definitions.	Explicitly emphasized.
Relationship Building	Importance of establishing trust with the patient for intervention.	Emphasis on long-term authentic relationships with community.

WHAT DOES COMPARING THEORY WITH PRACTICE REVEAL?

Conceptual guidelines and publications for cultural safety with Indigenous peoples are broad and non-specific to work with children. None of the definitions in the literature explicitly used the term trauma, historical trauma, or trauma-informed approaches. Rather, the notion of trauma is implied in relation to harm reduction and promoting safety in the context of historical and ongoing oppression of Indigenous peoples. Furthermore, only two of the eighteen definitions used the term “decolonizing” as integral to cultural safety, in the sense that one is not only reflecting on their social identity within the context and sharing power in a therapeutic relationship, but also actively undoing colonial healthcare practices that continue to cause harm.^[58] The relative absence of trauma and decolonization as core elements in theoretically defining cultural safety paints a picture of risk management in Western literature. That is, as Cultural Safety is taken up beyond its Maori origins in New Zealand, definitions lean towards the language and concerns of risk avoidance in healthcare, rather than an active stance towards a conceptualization of cultural safety that aligns with the ethics of reconciliation and undoing harms.

What the guidelines on cultural safety do emphasize is the right to self-determination, particularly in literature developed by Indigenous-led organizations. Although empowerment, strengths-based approaches and self-determination may be used interchangeably, there are important distinctions between each of these. Self-determination is more than a respectful attitude towards people’s right to choose, it is a political right for all peoples to determine their own economic, social, and cultural development.^[59] Further, in Indigenous worldviews, ‘self’-determination cannot be understood from a Western perspective of selfhood, rather, this relates to both individual and community engagements.^[60]

When practitioners defined cultural safety, they emphasized their own role in empowering families and recognizing individual strengths. Their conceptualization was within a psychological-therapeutic framework rather than a political one. The focus on trauma and trust thus paradoxically speaks both to a deficit-based medical model as well as the relational depth and understanding required to build healing relationships.^[61, 62] This shift from theory and principles to actual practice-based definitions is complicated. The experience of committed practitioners working with/in Indigenous communities reveals an uneasy and ongoing grappling with the ethical, moral, pragmatic, and philosophical demands of developing culturally safe paediatric rehabilitation and care.

EXPERIENCING THE JOURNEY OF CULTURAL SAFETY

Cultural safety is experienced as a lifelong journey by practitioners. Not a destination or an outcome. There are many paths, each with its own guideposts and bumps along the road. All people working with children and families in Indigenous communities are on this journey and must navigate the complexities of their role and position within each community. Where does this journey take us? What kind of journey is it? The stories shared by practitioners help to guide us on our way towards answering these questions. Each person and community are unique, and every person experiences the journey towards cultural safety differently. When proposing this project and describing her understanding, Jessica Jackson-Clement shared:

To me when I think of a journey, it's like... going for a walk in the woods and you know if you go by yourself, you might see a deer, you might see a waterfall, but then somebody else is going to take the same trail and it's going to be different. It's all about your perspective and how you're going to take it in, and again it's about reflecting about how that journey is for you.

This journey has five guideposts: embarking on an expedition, becoming unsettled, building relationships, engaging in reconciliatory practices, and the joy of the journey. These themes are described, then we follow practitioners in their own stories and experiences of working with Indigenous children and families. The themes are not separate or sequential. Don't worry about "getting it right." Just keep your heart and mind on your path.

I think you have to live it to understand it. It's not something that you can teach to any new workers that will go anywhere in a remote area. You have to tread with compassion.

EMBARKING ON AN EXPEDITION

Everyone starts the journey of cultural safety at a different place, bringing their own experiences, values, cultures, and ideas into the communities they work with. There are shared reasons why practitioners enter the journey of working with Indigenous communities early in their career. There is the desire for adventure, and to explore multiple domains of practice in a rural setting. Others begin from the value of helping underserved people, and a curiosity and responsibility to learn more about Indigenous culture and history. Our initial intentions have an impact on how we take our first steps into communities. Often, we might want to jump in and use our knowledge to help out in whatever way we can. Or we might enter very quietly, observing at first. Many feel nervous about performing in new roles and unfamiliar contexts, especially when we are forced to take on responsibility quickly. We need to get our bearings and learn about the communities in several ways. The more we know, the more we feel confused and disorientated. This happens when facing logistical barriers such as a lack of access to internet, difficulties reaching or finding community members, and flight complications to physically enter communities. Disorientation also comes in the tensions between our values and priorities, and that of the communities.

INTENTIONS

There was just so many different opportunities that I didn't think I would get in Maple that I would get here and just would provide me with more generalist skills and working skills and working with a whole variety of populations because this involved traveling. I mean, I went in having no idea what I was getting into necessarily. I just sort of liked the idea of working in Silverberry. It was actually my first job. I graduated from school and I knew I wanted to go somewhere I could practice as a generalist. I wanted to have an adventure and see somewhere new that I never had before, and just throw myself in. I had never to been to Silverberry and I just blindly applied on that basis and then obviously when I arrived, I realized that I had a lot of learning to do, and that it was more than just showing up in a new place. I didn't know the real history of Canada; I didn't really know what was going on and I had a sense that I was very interested in Indigenous culture. I had gone to a job fair and there was somebody from the Silverberry Health Council (SHC) there and just seeing the syllabics in Native language—just seeing that I was like: "Aah!! that's where I want to go, I know that's where I want to go." I just felt this pull. I just wanted to experience what's going on there, I just wanted to see and learn about it and the easiest way to get there would be to get a job. At that time, I felt attracted by learning about the culture, and then wanting to do something positive too. Wanting to be helpful and useful... but ultimately, I was looking for me and I learned a tremendous amount about myself. They didn't have the answers for me. I ended up finding the questions and the answers through other ways.

FIRST STEPS

So, I show up, I'm like: "Alright! Gung-ho, type-A personality! I'm gonna come here and I'm gonna get all this stuff." You come, you want to help, you have lots of knowledge, you have lots of ideas, you see all the potentials, you see all the things that could be developed and you just want to jump in, you know? Whereas for others, well, it was natural to be... not quiet, but you know, like low profile. For them, that's how they had to approach it—to start as low profile as possible, to observe, to try to see how to fit in. It's also that it was a bit hard for the SHC to find someone in my position. So, I came along, and then we hired another one, and we filled up our paediatric department. But with that in mind, a lot of us were new to the communities, so, a lot of us were establishing those connections at the same time, really trying to figure out how each community and service works. For some places there are different protocols.

GETTING OUR BEARINGS

And there is so much to absorb and learn. Learning a bunch of facts about a culture, it's fascinating, it's a good thing to do, but if you go to a mandated two-day workshop and you hear about 'what's polite, what's not polite, what is easier for a person to do, what you should do, what you shouldn't do within that culture.' You have to step back a little bit and ask: 'Does that apply to this person that I'm talking to?' I'm really glad that I also took more courses on it. But still, that's nowhere near enough to understand what it's really like. I will ask my Indigenous friends straight up, because, in Bearberry for example, the word Native is a very negative term. Like almost on par with the N-word I would say, almost. It's just used very negatively. And then in Silverberry people will use it a lot more freely. That was a huge cultural shock for me. And I would be very candid in asking "Hey this is something negative, is that a term I can use here," so I asked about that. The Government of Kinnikinnick, also includes a training. It was about four hours just explaining all the different nations here, the different languages, different cultural aspects, and the history.

DISORIENTED

Then, suddenly, I got more confused, which sort of told me 'oh so you're on a journey here!' You should be getting more confident but you're just getting more confused, but really, I was realizing there were no answers. Like, there isn't any support in place to provide this child I work with, with a good educational learning environment. I find that very challenging because the priority isn't on education as much in that household, as much as I personally value education for children. I'm a rehabilitation therapist who is being paid to provide these services and productivity is such an important value in healthcare that's been instilled in me and that's something that I still grapple with, and I think it's important. I don't want to just go and not be prepared at all; I want to have some sort of an idea of what I'm doing so that I can build towards something. I was stuck between feeling what I felt was the right thing to do professionally, and then what I thought what would make sense according to my personal background, and they were completely different.

This disorienting tension is more complex than a simple difference in priorities. When describing the living situation of Indigenous families, the term 'culture' is sometimes used as a euphemism to describe the ongoing effects of colonization and structural violence. A lack of resources, such as running water or adequate housing, does not equate with culture. When we struggle with these tensions, we start to question our own assumptions. The path to becoming culturally safer becomes blurry, and both the problems and solutions unclear. The experience of disorientation leads to questions, and we realize that we are not on an exciting adventure, but rather, we are stumbling on an unsettling journey.

AN UNSETTLING PASSAGE

The journey of cultural safety is unsettling. The initial misunderstandings and challenges that practitioners face help them to see the continued violence of colonialism that is often invisible or ignored by settlers. White Supremacy is a system of exploitation and oppression of people of colour, for the purpose of maintaining wealth, power, and privilege for white people. ^[63] White Supremacy values certain ways of thinking, behaving, deciding, and knowing from White, Western traditions, while devaluing or rendering other ways invisible. ^[64] Healthcare, rehabilitation, and education continue to be delivered in Western ways and are often inappropriate and ineffective within Indigenous communities. We have to come to terms with our complicity and active role in systemic violence.

We cause continued harm when performing unquestioned practices expected of us by our professions and regulatory bodies. We have to develop deeper and more layered understandings of how our professions and current models of practice are based on Eurocentric understandings of health, well-being, and disability. For example, current established norms of developmental milestones are not safe to use, as children grow up within different opportunities as well as worldviews. The logic of North American childhood standardized assessments has been demonstrated to be rooted in racist beliefs as a colonial tool for judgement and assimilation or segregation. ^[65, 66] Practitioners often struggle between knowing that their evidence-based ways of practicing are often not appropriate in Indigenous contexts, while still feeling bound to meet the professional code of ethics required of them. These codes of ethics are developed by, and upheld, by regulatory bodies that function within a bureaucracy intended to protect a presumed white public from a white-trained practitioner. ^[10, 67-69] This tension is tricky because culturally safer practices within Indigenous communities means letting go of what we were taught, and may even entail going against the mandate of the organization or professional regulatory systems. Many practitioners feel that they have little foundation to stand on. This is a systemic—not a personal—failure. Here is where the path gets muddy or may disappear altogether.

THE INVISIBLE BECOMES VISIBLE

I think our professions have been very good at marginalizing Indigenous concepts, Indigenous worldviews, and Indigenous values. There's a colonial structure in organizational administration. You see it, you feel it, and it does not serve us in forming the relationship of trust. You see it right away—it's even found in a piece of paper. If your registration form for a service, or for a centre, has a certain look, you're already creating that. You're signalling, you know, that this is a certain way of being, 'this is how we're going to have this relationship.' It's an old administrative pattern, and it's colonial. It says: "I'm an authority, you want something from me, you've got to jump through all these hoops, and you need to ask me in a certain way." There's a huge subtext to even a piece of paper to apply for services. Like, Non-Insured Health Benefits, for example, will give you a bath chair let's say every five years or whatever the heck their rules are. Well we know damn well that in Indigenous communities, if an Elder needs a bath chair, and her sister down the road has one, her sister's going to bring it to her. And now you go back to her house: "What happened to your bath chair because Non-Insured Health Benefits are telling us you got one two years ago? Oh! I gave it to my sister because she needed it." You know? And that happens all the time, with kids rehab too. If you think about those kinds of things, those are systemic barriers to equitable service. It's individualistic, it's not saying: "Oh the community needs this, the community needs access to equipment, so maybe there should be a store of extra equipment around so that people can use it." It's all individualistic and it's based on treaty numbers, and how often people should have things. And as rehab professionals we have probably consulted with the federal government in the past and said: "Oh well a person with that diagnosis should only need a new wheelchair every five years, or every three years." But that's not how it works in Indigenous communities. If someone has a wheelchair, and they don't need it as much as someone down over wherever they need it, they'll give it away to each other. If you think about that as an intervention, and how much of that relates to an Indigenous view of the world. Indigenous worldview isn't that you keep it to yourself and store it in your closet for the next ten years. You share it with somebody else who needs it more than you.

I mean, think of how education and healthcare are setup. A school's structured in a very colonial manner and expected way of being and some kids aren't used to that. They come from a home that has chaos and has very different boundaries and things like that. Then I go into a school and it's like, 'oh my god, they're supposed to like follow this rule, follow that rule, line up, wait,' you know, all those things that these kids may have never even had any exposure to prior to being five years old. Then all of a sudden, they get there and they feel like crap in Kindergarten because they're judged based on their inability to do that. They never had those experiences. We see that all the time and it bothers me because when little babies are coming to school thinking that they already suck and they're in Kindergarten—what does that do to your self-esteem at that age? And while some of us work in Silverberry, we also have to fly in to Willow every 4-6 weeks, which depends on the weather.

I don't believe the consult model is appropriate for First Nations communities in our isolated remote areas, and telehealth is absolutely not working as especially we're seeing during the COVID crisis—a lot of these communities don't have access to strong internet. Even I'm struggling here in Northern Oak with strong internet connections, let alone you hit families in poverty that don't have access to technology, they don't have access to phones, they don't have access to computers, they don't have an internet connection at their house, so it's really hard to reach these families via telehealth as well. I'm just not a fan of the research that comes out that says telehealth is the way to help support our families in isolated and remote areas.

COMPLICIT TO VIOLENCE

I think my frustrations have transformed, and I am more frustrated with the system. Maybe more so because I feel like things just continue to be done in the same way and it's not necessarily working. Maybe it's working in some ways, maybe it's more of my rehab aspect, but there are aspects that are just not working. And, again the primary care team in Silverberry is a fairly new team, it's been only around for three years, this is all work in progress and maybe I'm just being impatient, but it just feels like we continue doing the same things that have always been done and that maybe don't always work. But they do work in some ways and for some people, and I know people do appreciate the fact that we're coming, and we are providing service where there has not been any before. So, we are filling a big gap, but we're filling it up in our ways I feel like. I keep challenging myself, that's why I'm telling you, I'm still going to Willow, I'm going to the same place without having a clue what to do. Trust me that's super uncomfortable for me. I don't feel like the professional, I feel like I'm barely hanging on by a thread when I'm there. I cry every night. The first thing I do is I go back to my hotel room and I just bawl. Part of it is because it's so sad. It's so sad because I know that they have one of the highest suicide rates in the world, it breaks my heart because of that and then I see what's happening and it's like shocking and so I cry, I go back and every single time... and I hate being there and I complain about it, you should hear me before I go to Willow. I'm like 'I don't even want to go and I don't even know why I'm going anyway' and I go on... and then I'm always happy that I went... but yeah, I have really emotional reactions to some of it because it's so shockingly heartbreaking.

UNDERSTANDING OUR POWER & SOCIAL IDENTITIES

Because of the whole history, because of cultural genocide, because of all of that, it means that there's a huge chasm between me and any person who is not White, because of all that history. And what I know now, what I understand better now that I didn't know then, is that just by being White, I bring all of that with me no matter how nice of a person I am, no matter how much I care and how much I want to do that, I bring all of that baggage just by showing up. But like, I didn't understand that my presence brings violence, right? And so, people were responding to me accordingly. And I couldn't understand what they were responding to. I was like 'why are people treating me like this? What is going on?' I could see what's going on but because I don't understand that historical piece and what I bring to the table just by showing up, I can't unpack that, and I can't figure out how to be differently. I can't understand the extent to which tremendous humility comes even before the starting point because of that. So, when people come into Silverberry or Bearberry or Willow and they don't have the relationship or they don't have the ownership to build a relationship within these communities and put that first and foremost, it's actually very harmful to the community and the community members. It has the result of further traumatizing these communities and families because these families are so under the context of the healthcare professional being in a huge power imbalance with them. Their history of the sixties scoop taking away these children, the residential schools, to social workers removing children from families. Or I find that the families I work with are really terrified of healthcare professionals and even if you come in and you explain: "I'm a healthcare practitioner, this is my role." Even if it's as simple as "I work with fine motor," you represent a huge power imbalance to them and you represent someone that has the ability to take away their children as a non-First Nation's person outside the community. It felt very uncomfortable for me to be told by a Silverberry person, or for me to understand that what I am saying is being pushed back against not because of the value of what I'm saying, but because of the color of my skin, because of my origin right? That I'm being treated a certain way because I am White, I am a settler, however you want to define it. This is a reality that people who are racialized deal with every single day, but as a White person, I never in my life had to deal with it until that moment. And I suppose there were some ways that I was treated differently by being White in general, in my practice. Generally, people were like okay, you're the professional, you're the expert, we're going to listen to you. Which is again dominant culture stuff, but that was the first time where I was in a position of less power, because this Kinnikinnik First Nations person was higher in the SHC than me, and they have the power to say: "No, I'm not going to listen to what you're saying because you're White." For me to actually feel that power differential was extremely uncomfortable.

PROFESSIONALISM CAUSES HARM

And so, I was doing an initial assessment with a patient being in acute care in the Silverberry hospital and she was discharged home with her family, because there is a lot of multi-generational living around there, and it was really traditional house in the sense that there is caribou on the floor and stuff like that. She didn't speak English and I was in the living room and I had my paper and pen and my assessment that probably me and my colleague had created. And I was talking to her, and it's all very deficit-based: impairment, safety, you know, all these things. Safety is a very Western concept too, don't let them kid you, the idea of safety and risk management that's all Western stuff. Anyway... I'm asking her about these questions and then she finally said to me: "The way you are talking to me right now, makes me feel like I'm not going to get any better." She was upset, and I thought "Oh god." I just kind of put my stuff down and I just sort of said "Yes, I see what you are saying" and I just let her talk to me, and she gave me a piece of her mind! But that's what I should've done in the first place, was let her talk to me. To ask her "Are you feeling ok, do you have any concerns?" Just very open-ended, not have to sit there and ask her about five hundred things that don't matter to her, all centered on deficit. I talked to my coworkers about it later, but the thing is I knew that it was wrong while I was trying to do the assessment. Because I knew better from a cultural perspective, and I didn't honour my own feelings about it, my own intuition, my own knowledge. That was a harsh lesson that I've learned.

I'll tell you one experience as a graduate student that has never left me. I was really a good student and the professor asked me to do some work with her for money, and to do testing of some kids because she was getting very behind. And I felt so puffed up about that. I really liked this teacher and admired her, and I thought: "Wow, what a great opportunity." There was an assessment with a young boy, who was—I think—eight years old. His mother worked a lot with him. And I did a whole battery of tests because he was having difficulty in school. And then I sat down to present the results to her. She just wept and wept, it was just... I broke her heart. She was so hurt by what I had to say. I had never anticipated that impact, never. It was needless—it was needless, right? It really forced me to ask: "What did I do? What does this mean?" It just forced me to question everything. I took a completely different track after that, but it never left me. I saw how I broke her spirit; she didn't know me at all and I had such power... such power because of the position. The role that I was taking in the assessment and all that. It really made me realize the power and the authority that I carried without even intending to. There had to be a better way because I certainly did not help this family with what I had done.

In rehabilitation, I don't think we have a lot of interventions that are based on Indigenous worldviews. An example of this is even how disability is viewed. It's viewed very differently in different places. When I am up north in a community as isolated as Willow is, children who have disabilities are viewed very differently. They're not viewed as having deficits, in fact they are often viewed as being closer to the Creator. They're special because they're closer to the Creator than we are. They're not seen as problem; they're often treated with reverence in some ways. In that view, the problem isn't the child themselves, it's how they're perceived in the world. And it's around peer relationships and things like that, so the intervention should actually go to the peers, not the children themselves. That's a whole different way of looking at something. We are so focused on developmental skills for example, and in my experience and my clinical observations, the developmental scales are a very Western concept. The milestones that kids are supposed to be meeting by this age, by this age, by this age, whether it's social, whether it's motor, whether it's emotional, whatever it could be, language, they're not the same—especially language. Which means that the interventions that we have available to us to try to work on those kinds of things may or may not be welcome, or appropriate, in those situations.

This notion of assessment, the cultural appropriateness of some of the outcome measures we use in Bearberry school, they are all developed in European settings for European children and they're validated for those cohorts, and we utilize them here because they are widely used internationally. Lots of them don't fit our context, and everyone's aware of that, but I guess we don't have the time or the resources to create our own or critique it in a meaningful way. We have to ask: "Who are we targeting with assessments?" I think it's not just the content of the assessments, but even the underlying assumptions of the assessments themselves. Standardization is a neo-liberal, Western kind of thing that assumes there can be one truth. That everybody will fit into these boxes and let's just—like a factory—push them through it to find out who fits where. But everything needs to be context-dependent, and also who needs to be the object of assessment? We don't want the numbers, we don't want labels of severe dysfunction or whatever. We don't want. It's not helpful, and it's distancing because you're the one who has the power to assign these labels that stick, that wound. There's no benefit.

UNGROUNDING IN CLINICAL PRACTICE, LOSING OUR FOOTING

My day to day, how my day was spent, the time that I spent and the extent to which I was productive to White standards felt terrible every day. I kept thinking “I can’t do this, there’s no point in me being here, my being here is stupid or it’s wrong to be paid to be here in this way.” I couldn’t come to terms with that feeling because I couldn’t give enough value to what I was doing. I couldn’t understand what I was doing enough to value it and to rebel against my own professional identity, back then. I feel like that’s what I needed to do because I needed to do my due diligence: I needed to put in the chart note to make sure that I’ve done what I’m supposed to. That’s the rules, that’s the lineup of how it works. And yet, that’s not what I was doing. I was building relationships with people, not intentionally so, but because I was involved now in the system of having referrals, and somewhere in the assembly line of things happening, I was involved with people, and along the way of being part of that system, I was talking to people and I was getting to know them—even though I felt terrible about it because I felt like that’s not what I should be doing. I was stuck between feeling what I felt was the right thing to do, and then what I thought what would make sense here and now, and they were completely different, and so I had a choice. Either I was going to do what felt right to do, which I was learning had a better outcome, but then I would feel terrible about having done it because it didn’t fit what I thought I “should” be doing, or I would do what I thought I should be doing and it wouldn’t work. It was a conflict for me because I was stuck with my definition of what my professional identity is and what my role is. That was the conflict. In retrospect, that was the conflict, because when I did what I felt was right I was learning that was generating a positive response, clearly, that works, right? It works and yet I always struggled with: “But that’s not what I should be doing, this isn’t what needs to happen, I’m not doing my job as a rehabilitation therapist.”

I don’t feel like it’s right or fair, that universities give an education to a professional, and then they go off to an Indigenous community and they, as an individual, have to struggle to figure out with the community: “How does this work in terms of my professional order?” The whole system I think, we have a responsibility to be pushing back, to not leave it to the individual. That’s unacceptable. You can’t. There needs to be an openness to practicing in a different way. I do know individuals who have been challenged by the order, and it’s not fair, it’s not right. They get into difficulties.

A DIFFERENT PATH

Because it's like "What are we doing here? and who we are doing it for? To think beyond the obvious and looking at what our services mean, what they mean to the family, do they mean anything for the family? What's important for this family? And for this child, who really, we're there for?" You have to understand your assumptions, there are tons of personal assumptions which I also want to deconstruct, but what are the assumptions in the profession, about how you operate? And I think being aware of those assumptions is the beginning because if you're not aware, then you can't do anything about it. The same way that you bring violence to the table by showing up as a Settler rehab professional. If you don't know that, you are going to be way more violent than if you do know that, so I think being aware of White culture, of what that means, is a huge thing that people can do because it will help them understand that what they're doing is violent, which then opens the door to doing something different. But that awareness is the first piece.

It is only through unsettling and losing footing that the need for a different path becomes evident. Unsettling involves unlearning, challenging, and questioning Western ways of knowing and being. Practitioners can then begin to ground themselves and find their footing within community, and tread on a path towards relationships and safer practices with/in Indigenous communities.

BUILDING A RELATIONSHIP ON, AND FOR, THE JOURNEY

Our notions of relationship-building can be quite different across professional, personal, and Indigenous cultures. Relationships take time, particularly with the constraints of service delivery models, the need to build trust, and tensions between worldviews.^[70-72] This relational time is very different from the clinical time of goal setting and discharge planning.^[73] Practitioners re-position themselves in order to develop trustworthiness and respect, and to have a place in, or even become members of, the community outside the bounds of "the clinic." They do so by participating in the everyday with the community. The realities of building relationships will differ, for example, when working as a fly-in clinician versus an in-community clinician.

Practitioners inadvertently, and with the best intentions, cause harm and irreparably damage relationships. Making mistakes can be understood in multiple ways. Clinical mistakes are related to the lack of cultural adaptation of interventions. In an Indigenous context, the mistakes also go beyond the biomedical to reproducing colonial harms, such as education and rehabilitation that aims to assimilate Indigenous children to settler norms. Practitioners can also miss what is at stake and what actually matters to families and communities.^[74-78]

Meeting people where they are at is both literal and metaphorical. We need to meet families in settings where they feel most safe (their homes, the school, the clinic, a public meeting place). We also need to meet families in terms of where they are emotionally, financially, socially, culturally, and politically while recognizing that some days therapy will fall to the bottom of the list in terms of a family's priorities. Meeting people where they're at is about respect, sharing power, and acknowledging that the best way we can offer support is by being present. This requires moving beyond professional boundaries to connect with families as fellow human beings. Sharing this type of vulnerability means to authentically understand, accept and reveal one's own imperfect humanity. We need to reposition ourselves to find our place within the community rather than trying to work adjacent to it.

IT TAKES TIME FOR TRUST

It's my job to earn trust and not assume that it can be given or that it should be given. I'm not owed trust just by virtue of being a practitioner that thinks they're doing a good job. You can read up all you want but you're not going to know the family until you know the family. It's a lot of time and trust building and just being present and being open and understanding so those families can be honest, and I think part of me maybe knew that, but I wasn't really pushed to experience that until I started working in Bearberry. You have to go beyond your rehab room in the school on a weekly basis, you have to show your face, you have to be consistent for years to prove to them that you are trustworthy, that you have the community's best interest at heart. You have to talk to people. Now that I understand that violence piece and what I bring to the table and all the history, then I could understand that "yeah! It's going to take months; it's going to take years." Because when you build a relationship with those families they feel safe to tell you that it's not a good time, like maybe it was a tough day for them or there's something beyond that, so they feel safe that you're not going to go report them to the ministry of child welfare and have their kids taken away just because they're not engaging in a rehab service.

If you have a child in crisis, there's nothing you can do until you support the stabilization of the emotion, and you do that because you can do it only if they trust you, and they feel safe with you. They need to feel safe with you. So, I link that back to cultural safety. When we're working with the child, or the parent, or whomever, we need to think about that background of the neuroscience of relationship. That we can feel each other in the room, you know, we can calm or activate each other. And that it comes through trust. You cannot feel safe unless you have a trusting relationship. So, if that takes time before you can do your assessment or present your clinical recommendations, it's time well spent.

BUILDING CONNECTIONS & WORKING TOWARDS BECOMING PART OF THE COMMUNITY

We often say: “You can go up North, you can go work in any area where you’re going to be out of your comfort zone.” But you’re going to be the outsider, so if you just go in to do your job and that’s it: “I’m a therapist, what can I do for you? Okay this is this” and then I go back. If you go with that attitude to a place like Willow, it’s going to be hard for people to agree to open to you and to connect to you. The advice I was given and that I repeat in my head is that things happen very slowly. The more I can just become part of the community, the more trusted I am, the more my ideas will be heard. It’s an invitation to the conversation that comes from them, not an intrusion from me.

For example, I talked with the head community coordinator at the Silverberry Hospital and he wrote down my concerns and my requests or recommendations for certain people, and I always try to phrase it like: “I’m working with these Elders and I’m just trying to make sure that they’re safe at home,” and kind of pull people in, making them realize that we have the same goal or that we want really the same things. But anyways, after I had this conversation, I left and I was going to the nurse station and the coordinator actually ran out after me and he called me and he brought up one community member that requires help and he says: “Oh, I think he’d benefit from a home visit” or something like that. So, I try really hard to be a member of the community however that happens. I go to the lunches, I go to the craft sales, I go to the Goodfood Box, I go to the Annual General Meetings at the Band or the health station, whatever that looks like. Whatever people want you to be and participate in—like totem pole raising—whatever it takes.

Of course, it’s harder in Willow, because we don’t live there, we fly in and out. If you do have somebody that flies in to do an assessment, it’s about helping people first bring awareness to what works and what doesn’t work in terms of building trust. An awareness to what the barriers are, what has hurt people, and what we do not want to do anymore. Our whole team created these ‘get to know your clinician’ cards’ which has my name, photo, what I do, a fun fact about me, and has my contact info. When we’re in Willow and we’re seeing a kid you could say, ‘Put this card on your fridge’ or ‘Tape it on your wall so you see my face, so you know who I am, you know I’m a person.’ It’s really hard because there’s so many people that come in and out for parents and children to connect with who you are and what you do. Trying to have something that’s a bit more present to hopefully foster a bit of a connection is a big one.

STUMBLING ON THE ROAD: MAKING MISTAKES

The issue, I think, that people have to deal with in practice, is that we are very episodic in our practices with people. You come in in the middle of the story. You don't know how this patient got their broken leg. You don't truly understand what in their upbringing makes them think that it's reasonable to jump off roofs. You do as much as possible, you try and understand how they got there, why they got there, and then you try and apply the things that you actually can do, that you know. When I think of my early days in Willow in particular, I'm horrified. I'm really horrified. How I went in, I was arrogant, I thought I'd had all this education, I'd had all this experience, that I knew what to do, and I didn't ask enough questions about: "What is this place? And what do you value? And how do you talk about kids? And what's important to you and your family and community?" I made lots of mistakes. I learned a lot through that. I had no intention to harm. It's that whole 'do no harm,' right? Well, you really need to think that through because there are many ways that we do harm by repeating certain professional practice patterns, and not being reflective about what the whole context is that we enter into. Whether it's a culture of a community, or of a family. Because I do look at culture on that continuum. It requires an enormous amount of thought being brought to every professional act. It's tiring but it's worth it. It's certainly how I prefer to be.

So, yeah, in those facepalm moments, I do try to reflect on it. Usually I have the anxiety that goes with it, but then, there's not much I can do. I can just learn from my mistakes and try to apply it with my new clients. And then, I feel like with that family, I'm still trying to repair that relationship, but I don't think it will ever be what it could have been. That's what I do: Just reflect and try to admit when you're wrong, and sometimes it doesn't make a difference, it just, it just kinda is. It's very painful. To have those realizations about yourself, but I think I instinctively recognized that they were shaping me, that these mistakes are important moments to pay attention to. It really awakened my mind. I would say that it was the walking beside families that were in vulnerable situations because they had a member with a disability that shaped me the most. Because I continue to do that in my professional and personal life. I've been doing that for a long time. So, my learning continues, and that's been profound. If you don't make mistakes, then you're not challenging yourself enough. That's my opinion about it, that's the bottom line.

BEING VULNERABLE & SHOWING VULNERABILITY

My education tried to make us into these little machines, and I thought that's how I was supposed to be. But now with all my experiences I've realized "No!" I have to be who I am at its rawest, at its core and that's how people will accept you in those communities. That idea of authenticity doesn't mean that you just act like yourself. Authenticity means that you lean into who you are as hard as you can, into the spots that are even the weirdest. You figure out who you are as a human being, as an individual, and then you be vulnerable and you understand that in those Indigenous spaces, if you don't come with that palms-up approach and your heart is open, then you won't do well there. When I go into the Bearberry school, I sit down in the staff room and I have a cup of coffee and I try to chat with people often. So it doesn't matter who it is, I don't care if it's a janitor, I don't care if it's the education assistants, I don't care if it's the principal— whoever it is, I will sit there and try to let them know me a bit. They'll say: "Where are you from?" And I'll say: "Oh I live in Northern Oak just outside of Silverberry, I have two kids." I'll just start to tell them a bit about myself because they always want to know where you're from and who are you, and "Why are you on our land?" That's what they want to know. I'll tell them a story, I'll try to tell them something funny, or something that makes me vulnerable. Something that shows them who I am as a human. There has to be space for laughter and connection, especially in such unjust conditions. It's so important to be human in our role and I think that somethings can be lost really easily. You have stuff to do as a professional and keep your professional ethics, and it's really important to be human and to be vulnerable and who you are and let people see you. You have to make a personal connection because otherwise it always remains theoretical and very clinical, and that enables you to distance yourself from it. We try to not let that happen because we're all human, so we are sharing the human experience. And then that enables the development of the trusting relationship.

MEETING PEOPLE WHERE THEY'RE AT

A lot of Kinnikinnik families are dealing with so much trauma in their own lives that focusing on their child, what their child needs in terms of disability support is not a possibility. They're focusing on trying to get their kids fed and dressed, so I really need to meet them where they're at, and I think that's how I get accepted. Families often engage and disengage in service and that's ok, we don't discharge unless they want to, but we're respectful that when a family is in crisis they don't engage at that time. Answering phone calls can be difficult for them, making appointments can be difficult for them, attending appointments can be difficult for them, being on time can be difficult for them and we're very non-judgmental and we accept them where they are at that time. We know that's not necessarily a reflection about how they feel about our services, but maybe it's a moment in time, that's where that family is at, and to give them that freedom to not answer their phone calls for a couple weeks if they're in crisis.

You've got to meet families where they are at, and some days that's a ten-minute visit, some days they're going to decline visits and say 'No thank you', and that's ok, it's not personal. I think that healthcare people have to establish a culture of being comfortable with letting people be as they are and doing what you can do in the setting that you're in without trying to modify people. Just realizing that rehab and maybe occupational therapy or physiotherapy or speech and language therapy is not the family's priority right now because they can't, they just can't, there's bigger problems, there's bigger issues. They need to get through the day, they need to feed their family, even with mental health—they need to get up out of bed, right? And maybe executive functioning is challenging for them and to have empathy for that and be ok with that and not to link it with my ego as a human. Not to link it with whether or not I'm a good practitioner because I got that child to hold the scissors properly at the end of two months—its more about just being there for the family and sometimes that means that you don't know if you're even doing rehab. Maybe it's sitting there, drinking tea for an hour with that mom as she tells you a story about her domestic violence and her past and just to be there. I started asking open-ended questions to families: "What does your life look like? And what does your child's life look like?" And then I started understanding the challenges they were facing day-to-day. Then I was really able to identify priorities for families, see where they were at. And that really started building relationships.

MEETING PEOPLE WHERE YOU'RE AT

When you're being vulnerable and building relationships, you can't be a wannabe Kinnikinnik-en, or a wannabe Bearberry. You have to be whoever it is you are. You better figure out who that is before you start messing with trying to treat people. That's what you need. You need to know yourself. And you need to know where your comfort level is. I'm very comfortable in the kind of work that I do, but I'm also very aware that it is not really the kind of thing that a lot of people want to do. You have to understand your own background. I've had several 'click' moments, where something drops into place and your viewpoint shifts. And they've all been about things in my own set of assumptions where you realize you had gone through this set of assumptions, not necessarily adhering to them intellectually, but you'd been proceeding on them. It's the professional who has to be really introspective about their own thinking, how they deal with people. Like, why are you reacting to this person this way? How have you come to the decision that they're not trying? Is it because they're not trying? Or is it because you're not seeing what you see as evidence of his trying, which maybe a culturally determined thing. I'm keen on finding support in SHC and at the Bearberry school, and there's also an incredible Facebook group of trauma-informed educators that is a wealth of information and support that I often go to a lot. I take that part really seriously, that I feel supported in the work, because it's simply too much otherwise. But it's where my passion is, so I know I need to do that stuff. I have to be willing to learn a lot and learn it quickly. And also, I just need to know that I just don't know, because I'm an outsider. I always keep in mind that I won't ever truly ever know, but it just motivates me to learn more, understand more. I'm never going to fill that entire space of what I need to know, sometimes I will never know, and I have to accept that. But what can I do with what I have, with what's available, with what I do know?

REPOSITIONING OURSELVES

I know as clinicians, as new students, we're all super eager, "Hey! let's work on this!" Obviously, we need to work on this one fundamental piece, but sometimes families are not there, and you really need to reel it back. I can't change the environment, I am the one who has to change to be a successful part of the environment, and that's what we can be good at, right? I really just try to fit the mold that I see as being needed in this community. It's a lot about learning the culture, even learning the language. Respecting Elders and knowing the key people that the entire community looks up to and making sure they really approve of me and love me and see that I'm doing good work. Because then they mention "Oh well have you talked to [consultant name]? You know, she does this!" And that's how my services get respected, it's by word of mouth. That's not going to come from me and my white skin, it's going to come from respected people in the community.

As the extent of structural violence becomes visible to practitioners, and as they come to accept their complicity, their vision of their role changes. They shift towards relationship-centred care and minimizing harms. The moral tensions of the work move well beyond a consideration of professional ethics and cross into the deeply personal. Practitioners experience a questioning of their professional identities and assumed boundaries in order to engage more fully in their practice with Indigenous communities. In so doing, they learn approaches and strategies that actively resist systemic racism.

UNCOVERING PATHS TOWARDS RECONCILIATORY PRACTICES

Practitioners need to find new paths and ways to practice that work against the values of White Supremacy in healthcare disciplines. Consultants have shared stories that illustrate paths to follow that run the range from reconciliatory and relationship-building, and on the way to decolonial in its humble rather than political meaning.^[58] That is, they examine the influences and injustices of our current systems and resist these, while simultaneously engaging with Indigenous worldviews and ways of doing.^[13, 79] At minimum, this path fosters respectful practices. At best, by uncovering these paths, practitioners engage in honoring Indigenous people's right to self-determination.

There are three overlapping paths that practitioners find. The first is to go beyond reflection and actively resist the harmful ideologies of White Supremacy and neoliberalism within healthcare and rehabilitation. This involves confronting our notions of professionalism and attendant behaviors, developing our tolerance for discomfort, and becoming activists to help families have their voices heard in organizations and funding agencies. We need to reorient who we look to for mentorship in order to engage with the power of Indigenous families and communities, as power continues to be denied to Indigenous peoples and communities.^[80, 81]

On the trail, therapists need to identify practice frameworks that are developed by and for Indigenous communities, and that name and address the effects of colonization. One guidepost is trauma-informed care which helps us understand the widespread impact of collective trauma and how it manifests in those affected.^[36, 37, 57, 82] This approach helps us shift from "What is wrong with you?" to focus on understanding "What has happened to you?"^[82] and to respond accordingly in culturally and evidence-based ways. This culturally responsive approach engages with both trauma as well as resiliency. As declared internationally, Indigenous ways of teaching and healing must be recognized and valued.^[83] Bridging Western and Indigenous knowledge is known as two-eyed seeing. Two-eyed seeing was developed by Mi'kmaq Elders Albert and Murdena Marshall, who describe it as "To see from one eye with the strengths of Indigenous ways of knowing, and to see from the other eye with the strengths of Western ways of knowing, and to use both of these eyes together."^[84] In so doing, practitioners learn to experience connection to land.^[85] Finally, there are practical everyday strategies that minimize harm, foster respect and relationships, and push against systemic racism. These can be quite varied and depend on the community and the practitioner. There are, however, three strategies that are repeated on the consultants' journeys. The use of social media to communicate in northern and remote settings may not be 'professional' in terms of confidentiality and portrayal of expertise yet is an effective and respectful way that is contextualized to peoples' realities. Alternatives to the use of invalid standardized assessments are proposed, along with ways of documenting practice that reflect a critical and more fair professional impression. This type of documentation can also be used in activism and advocacy.

HIDDEN PATHS: DECONSTRUCTING PROFESSIONALISM

WHAT DOES IT MEAN TO BE A “PROFESSIONAL”?

Professionalism is not about arms-length, inauthentic behavior where your agenda is number one. Professionalism in Indigenous territory is being vulnerable, it's being humble, it's being respectful, it's making mistakes and acknowledging them, it's being human first and a practitioner last. There is a mystique around a professional, and that comes with a certain title and education. I think transparency about ourselves and our limitations is really important as a foundation for developing trust.

For example, there's a colleague who worked part time in Silverberry this year. She would come in, and she just did everything by the book and she just missed so much, you know, because she wasn't able to go off her schedule. On a day where I followed my schedule, I would be like "Oh my god, I followed my schedule today, like it's a miracle." And she would come in one day a week, and it was a real wakeup call to me to think: "Oh, I'm so jealous of her performance management... but she's missing the community aspect." It was helpful for me to see someone try to do that and then me be like, "Nah, I'm doing alright." And that goes for every aspect of our work, not just schedules and stuff.

In Bearberry, at the school, there's a very strong emphasis put on just loving and protecting these children, so this kiddo may not be on my caseload, but if I walk by him in the hallway and see him sobbing or screaming, there's no way I'm going to walk into my next appointment. I'm going to stop if no one else is there and make sure that's taken care of. The community aspect in this school is unlike anything I have ever heard. There are no, "Don't touch the children; don't hug the children." Everybody's just like "Oh baby, come give me a hug." Everybody's somebody's auntie or somebody's grandkid and they're cousins. It's like a big family and I just feel honored to be a part of it. That really started building relationships because then families felt more confident to reach out to me and say "So, um, my child has a toothache. I don't know what to do. The school nurse is not doing anything about it. What do I do?" So obviously, it's not my job because I'm a rehab therapist, but again, if you go back, two years ago, we didn't have anyone to do that job for them, so I was the one who had to do it. I had eyeglasses that never made it to the community, so I would call people and say like "Where are the glasses? Why aren't they here? What's happening?" I was doing a case coordinator's job a lot. But then families really felt like their priorities were heard because at that time, well you know what, parents were like "My kid can't see, so why are we even working on this?" I guess that's kind of sketchy if you talk to any professional order. The regulatory bodies, I'm always like, 'Can you imagine if we got audited?' But my principal always says "I'll protect you. You are doing the job I'm asking you to."

It depends on where you work the extent to which you can push back with regulatory bodies and larger pieces. But I mean if you really have an interest in actually addressing health inequity, then that involves activism. And that involves pushing back, and then you need to make decisions. Does that mean you quit your job? How much can you push or not push? I know therapists who do not work in the governmental healthcare system for that reason, because they're boycotting White Supremacy. So, then they can make decisions outside of the bounds of that system. We do have power to make change. However, you know, it depends. If you go up through management, if you go through program development, if you start going into more powerful positions and you do have possibilities to advocate, to push for change at a systemic level—it depends on where you work, it depends on how you decide to work, it depends on what kind of power positions you take on at a systemic level.

SHIFTING THE BALANCE OF POWER

There's a very large disconnect between a lot of the funding agencies and government organizations and their attempt to reach First Nations families. A lot of the time the decision and policy making people are in urban centers and cities that are very disconnected from the communities, and disconnected from the families, and what their unique needs are. We're actually helping collect information for a new tribunal to challenge and advocate for these families. It's part of documentation, thinking of the whole community and what it would take, instead of just the individual patient. We want to come at it from a different way, we're in partnership. A parent or an educator also has expertise. And they're living with the person, either in a class or in a home, and all that, and we need a partnership. Going in with humility. Like I don't actually know, you know? Here's some ideas, what do you think? I recognize that I might not understand things from your perspective, but I'm really interested to hear what you think, and let's work together. I really like cultural humility because it positions the idea of difference as being between two groups. It's not about, "You're different." It's more like, "We're different from each other." And that I find important because then you don't have a norm and an 'Other.' You have like a blue and green, and they're different from each other. It's not that blue is the norm. I think that's really helpful for positioning ourselves. I think that opens space for power shifting.

MENTORSHIP - WHO DO WE LOOK TO FOR GUIDANCE?

The head of the rehab department in Silverberry, she's like a community pillar, and I'm very close with her and she's also just an absolute kickass human being and she really helps me when I can't figure something out. And the principal at Bearberry may not understand everything about my field, but he has a serious handle on Indigenous education in general. He tries to bring me down to reality a lot because I'm up here like "Yeah, I'm gonna!" and he's like "Yeah, no you're not. What you need to think about is this" and I'm like "Oohhh" and he really helps level me. I also have an Indigenous co-worker who is now a friend. She would come in and sit and look to me, then look at the corner so that she wasn't being imposing. This was a woman older than me who I had to be respectful of, and there wasn't an initial class for me. I had a lot to learn, and she was very patient and showed me, and modelled, which is one of the teaching methods that is often used in Indigenous communities.

At SHC we have an Elder in residence in our office who comes every Friday who is available for any new staff to do some introductions and some teaching but is also available every Friday for staff if they need to talk, or want to share or learn from our Elder, and even create programming together. So, I can—and in collaboration with an Elder—we are both kind of co-teaching a program and we touch on different elements; it's based on the medicine wheel. I've learned about the medicine wheel and by asking the Elder and by doing some research online and try to make sure that the Elder agrees with how we are presenting the material. Now our sessions focus on the physical, mental, emotional and spiritual realms of healing.

As an Elder, I know my team has the heart connection, all of them, you know. And whenever they're struggling, I know right away, and I zoom in on my team, and same with other staff members, they'll come and seek me out and you know, of course that heart medicine comes out. And how do we get through it? Because we're human beings. And so of course we're going to have challenges. Even though I have challenges, and I need to have someone there that I can reach out to. The circle is equal in our team. They've watched me for four years, and I've seen the hierarchy change to a circle.

Elder Good Talking Turtle

ON THE TRAIL - PRACTICE FRAMEWORKS

TRAUMA-INFORMED CARE

I feel like trauma-informed care and the trauma-informed classroom is the buzzword of the year. Everybody's talking about that, and that's great. Everybody should be talking about that in my opinion. It's also about the systemic trauma and racism. In Canada, being Indigenous, it just cannot be overlooked. I'm working in a school with Indigenous children, and those Indigenous children's grandparents and most likely great-grandparents were frequently sent away to residential school where many of them were abused, molested, and murdered. The very act of being an Indigenous child in school has trauma attached to it, a hundred percent. I view trauma-informed practices as a non-optional part of my work.

I see colleagues struggling with idea of historical and current trauma. We have to find another way for practitioners to open their eyes. When we're faced with challenging experiences in our work, we tend to very quickly go back to an old way of being and seeing because it's an immediate response—to fix, control, rehabilitate. So really what we're always trying to encourage is a reflective pull back: "You may have responded this way immediately, but now let's, now let's look at it. Let's look at it through a trauma lens. What do you think you were seeing? And what were you giving that perhaps was not furthering the context of safety, but in fact was a trigger?" It's continuous, absolutely a continuous effort to make it part of your practice. What we really try to do is create a common understanding together and a common language. A common language of trauma-informed attachment and safety.

TWO-EYED SEEING

In the Bearberry school there are Kinnikinnik-en teachers and support assistants, and they do have an important bridging role in helping to figure out between, the Kinnikinnik-en and Western ways of thinking. What works and what doesn't, and again, the relationship piece is super important because people assume you've got a job to do and you're just going to do it your way. That's what white folks have always done when they came in, so I have to actively demonstrate that I'm open to other ways of doing things. That's two-eyed seeing. I value their ways and they know it. I also value what clinical intervention does, and they value what we do. And they see the value. In the process, I have become a lot more open to Indigenous medicines and understanding the benefits, even though I come from a Western ideology in all my training. I have learnt to appreciate that Indigenous medicine has been around much longer than Western medicine. So how can I do both? How can I learn and promote both?

When they're going out on the land, I go with them. Even if I don't really have anything to do; I don't need to assess. I can't really look at 'attention' out on the land in the same way as I would if the issue was identified in the classroom, but I'm still going to go on the land because it's about being part of the community and I always learn something every time I do. There's the drum. The sacred drum. We actually brought drums for the kids in rehab as well, as little helpers for the Elders. And smudge, and all of that. And the teachings. Balanced with all of the other wonderful activities on the land. And talking to the trees. The Elders say: "Ohhh, hey, did you hear? Did you hear that? Did you hear that voice? The tree is speaking! Oh, my goodness he's talking to us!" We are all listening and discovering.

It's hard to explain—let me tell you a story. What happened is, two of the children were lying down in the lodge, and the adults were talking, and the energy, and that peace in that serenity, and I'm feeling it right now, you probably feel it in my voice. The little one, he fell asleep in the lodge, it was a safe place. That's what the sweat lodge represents, is this safe place. It's the mother's womb. It's the safest place that we can be, and when a mother carries us, that's a safe place. And so, in a womb, in the sweat lodge, you're in a safe place, and this little guy fell asleep. And someone said: "I think you better just leave him; he needs to be with Spirit." So many beautiful things happen there. It was like he was totally needing whatever it was from that lodge to rejuvenate who he is.

EVERYDAY STRATEGIES ON THE PATH

FACEBOOK AS COMMUNITY-BASED PRACTICE

My job is so much more improvisation and not 'by the book' than any other job I've ever had, and I couldn't work here successfully if I came in and said "Well, I need to have a record of every time a parent has contacted me." I created a practitioner Facebook account and that's where people communicate with me. I add people I work with to Facebook. It's also about being a part of the community. Not worrying too much about that professional boundaries stuff. A lot of people use Facebook to communicate. But on my organization's end, policy-wise, we're not allowed to do that. The way we work around it is that we have department coordinators contacting clients for us through Facebook, which we cannot do due to privacy reasons but that is usually the only way to reach some people. I'd say the biggest barrier to providing treatment and even assessment is the difficulties around getting a hold of families in conventional ways.

CRITICALLY APPRAISING ASSESSMENTS

Unfortunately, in some cases, standardized assessment results and diagnoses are needed in order to access funding and services. If a parent needs funding for something, and there's certain funding sources from the government, then the only way you're going to get it is if the child has a label. We're not going to make it up, we're going to have the relevant professional do the standardized tests, and give the label, and the score, and all that. With intent, because we have an intention. Whenever we have to do anything for the government that does not allow us to do it in the way that we typically do—which is starting with a strength and capacity focus—we are very upfront with the parent when we explain. For example, the family needs to apply for handicap benefits, and they need to apply for it every month if they have a child with a disability. And they need that money, because they have more costs. What the government needs to see is "The child can't do this," they're problematic with their deficit-based forms. They need to see that in order to give the families money. So, we'll do it. We can certainly describe the children that way. We just always choose not to. That's why we are very honest with the parent: "You want this money, then this is what we have to do. You know that we do not talk about children in this way, and we do not think this way."

We can't just use these assessments without intention, just because they are tools that exist. Things that we're not considering when doing assessments is trauma and history and access to opportunity and familial trauma. When I went to Willow that first time and I thought "For the love of god, what am I seeing here?" I tried to get history around what happened in that community in the last hundred years or so and there's no assessment out there that teaches me to do that in order to understand the children. What I do now is I tell parents that I need to get this background information, so don't worry about it, we'll just jump through it quickly. Then we just sit and relax and then we talk about what they need. What's the concern? What's going on? Why are they even here? Sitting down, not having my rehab agenda and just having a conversation.

Even if my parent interview takes longer than I want it to take, I don't care anymore. It's really important because as soon as a parent is on, as soon as you figure out what the parent needs, then it's a lot easier to have that flow in your session.

The key is observation, which is why you really need the trauma piece and the history piece and the Indigenous cultures piece to have a sense of what you're looking at, what you're interpreting. I take a lot of students in for their practicums and that's honestly what we practice. I tell my students: "I need you to sit there and play with the kid and you follow their lead." It doesn't matter what they want to play, and you get all this list of information because there's so much you can do with playing. I would say informal assessment is so much better. It helps you make that connection with the kid. They think you are super fun. They don't know that they have to sit there and do an assessment. A lot of it is observation with the child and parent rapport, but without judging parenting by Western norms. You need the historical and cultural piece so much.

In some of the communities I work in, the focus is not on how we can intervene to help individual children, but how we can work with the environment and the people around the children to restore balance. You don't assess the child. You look at what's preventing inclusion among the other kids. I have had to reflect on what does assessment look like from a Kinnikinnik perspective. How would a Kinnikinnik-en look at a child or a situation? And thinking of balance being off and ask: "What's needed here to restore balance?"

At Bearberry I spoke to the teachers that I have a good relationship with. I showed them the assessment materials I'm using for a sensory profile. And I gave the assessment tasks to the teacher and she said: "Oh, this is not the Kinnikinnik-en way." Then she asked me questions about how to support a particular student in the classroom, and I was like "Huh—okay so we need more information, but I recognize that this assessment's not so good." And she was like: "No no, you can still do it; you can still use it, but let's just talk about how you use that information."

After that, the team decided to have an open conversation about assessments. It was a community driven process where we brought together people who had something to contribute. From parents to nurses, and community health practitioners who are doing screens of children often through their doctor's visits and things like that. We brought people together, and we talked about how as a rehab team felt that screening was important and why it was important, but we also identified: What are the obstacles to it? Why are people afraid? What do we need to bring this in without creating fear and distance, without repeating the mistakes of the past? We had a very long dialogue about it, the community worked with us, and we really deeply analyzed it: How is the assessment presented? Are the questions meaningful? Would people misunderstand them? Are there some cultural obstacles to responding to the questions? How well do people understand them? We did focus groups with different parents at each different childhood stage. We made the evaluation process a collaboration that came from the community. Using the screening process now opens the door to a meaningful conversation.

I have to write up my assessments in a report, no matter how I conducted the evaluation, I have to find a way to document. I work a lot with educators who also have to write individual education plans for children; it's required by the government and all that. I worked really hard in my role to be within the guidelines of what we were forced to do by our order for charting, but to also take as much control as I could to create something that was not clinical, that was not stigmatizing. If you were reading about this and it's your child, and it's in black and white, and it's going to move with them, and it's going to go to the next school, and how would reading the sentence that your 'Child is aggressive.' How is that going to make you feel, and what benefit is it going to bring? Especially if that paper follows them in a system that is racist. Report writing can't be black and white; there's so many shades of grey in there, you have to consider, and you can't just say this is this. You can't just. And how would someone perceive this language? It's really hard. Especially when you think of submitting things for reimbursement or funding, like Jordan's Principle.

I hope I've gotten to a place where my reports are jargon-free and written in a way that families recognize their child and it is useful to them. Especially in Willow where children are still being removed as part of the millennial scoop and sent South into foster care. When I write my notes, I include my understanding of colonization and trauma and community priorities in my clinical impression, how all that might explain what I'm seeing beyond the standard western or medical rehab lens. I also put myself and my actions in the report: What have I done to help foster or break the connection. If a parent didn't show up with the kid for a session, is it because they are not engaged? Or is it because they don't know me, and my aim has to be to build a relationship? Or is it because another kid was taken away from the community last week and all the parents are scared now? Or did I say something rude in the community and now there is less trust? What have I not learnt yet that I should? I could go on. Writing in this way, it's the honest and fair thing to do. Especially when the paper goes into the bureaucracy for funding. I always write as if the parents, their ancestors, and the future generations are looking over my shoulder. What is the truth of the situation?

From an initial curiosity and an adventure, through unsettling and muddy paths, practitioners learn to ground themselves in relationships with and in Indigenous communities. The moral imperative to do more than reflect on their practice and minimize harms becomes a priority, and they learn frameworks and strategies to work against systemic racism on the ground in meaningful ways. Some become integral community members, and some become activists who use their professional standing and documentation practices to advocate for change. The adventure turns into a life-long voyage.

THE HEART & JOY OF THE VOYAGE

When practitioners first begin their journey into practice with Indigenous communities, they are often unsure about what drew them there or and their own understandings of what brought them there may have changed. Along the way, they come to terms with the difficulties of working within structures that oppress, and all that encompasses. Although this journey is fraught, practitioners find deep joy and meaning in their work with Indigenous communities. For many, staying on this journey is essential and necessary. There is no going back from what they have experienced and learned. They come to understand that this voyage is both about healing for Indigenous communities, and a deep repair for all of us who are living in colonial societies. The repair happens on a healthcare practice level, and also on a deeply personal level. It's a healing of the Heart and Spirit.

I love it, I just think I have the best job in the world, I really do. Real life is not these perfect families on TV, this is real and that's when you can connect and actually just support them however they need in that moment—it's so powerful. I do believe that I've gotten depth in my character, and depth in my humanity, and my empathy of how we see each other. It's a gift. It's a gift that takes a lot of time and you just have to stick with it and that's what I plan on doing because I love my job. Bearberry is a phenomenal community to be a part of and I feel like the work I'm doing is the most important work I've ever been doing.

People want to be involved with our school now because it's a group of incredible First Nation kids who have awesome stuff to offer. There's really neat stuff going on all the time, and it may mean that no two days are ever the same and that's way worth it. It's important to understand that you have every right to thoroughly enjoy your job. You shouldn't go to a job that you're doing because it's an important job and it's your duty. That's a kind of a trap. Because if you are doing your duty, if you're not enjoying your job, if you don't get satisfaction out of just the doing of it, it's not hard to see that you can fall into a process of feeling like: "I'm such a good person because I'm doing this terribly hard job, and that means I'm good." And you know where that can take you. It's not a good stance for a healthcare professional. It leads into beliefs like 'I really know better than you what works in your life,' and it's a very seductive thing—to feel important.

I find it beautiful, the strength and the power that community brings. I think that's what really draws me towards working in Indigenous communities. I really approach it in a way that I've come here to learn and if I could offer something that's really bonus to me because I can also make a living. I think what draws me towards it is exactly this idea that I do have so much to learn from it. I think there's a lot of knowledge in there that I think is important for non-Indigenous people to learn and respect, for their well-being. But I think it also goes beyond that, I think it holds a lot of values and truths that can help humanity at large.

There's a voice that still needs to be heard. And I know it will help not only Indigenous people, it will help all people. I know it will. It will help everyone. It won't just be segregated to Indigenous people. I am holistically against racism. All the people in Kinnikinnik are hurt by racism. I feel that pain. And my hope and dream, because Indigenous children on the spectrum have so much stigma, in addition to the impacts of residential schools and more trauma, and racism needs to end. And I feel that the only way is to bring all people together to understand. When you talk about Spirit, you talk about heart medicine. The heart has intelligence. And when we feed the spirit of the heart, and connect in a heartfelt way, we can help. I don't know how to explain it. It's just amazing what I see, what happens that way. I learned this from Sundance, I learned this from ceremony. I learned it from the vision. And spiritually there is an energy that comes through me that happens with the kids. And I don't know how I can tell people to get that, other than teach them how to connect with their heart. The muscle, the brain of the heart. So, that would be the way to try to explain it. It's hard to explain, but I hope I've given you something.

Elder Good Talking Turtle



WIDENING HORIZONS FOR THE JOURNEY

This guide narrates how becoming culturally safer is experienced on an individual level, drawing on the stories of practitioners who are predominantly settlers. This guide does not represent the whole picture, as it does not include the perspectives of Indigenous families referred to rehabilitation services, or Indigenous communities that organizations intend to service. This guide does not delineate how a culturally safe federal, provincial or Indigenous organization is established or functions. Only one administrative-level consultant shared their experiences, and it seems that at the institutional or organizational level, the practice of cultural safety begins to overlap with the broader ethics and actions for reconciliation as power-sharing and a healing of relationships.

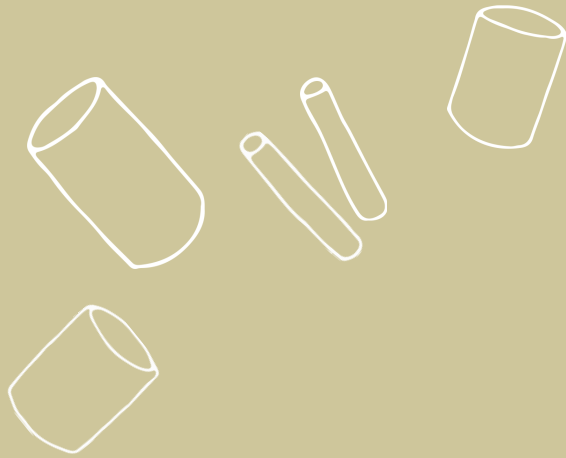
Within this organization we've really created a system of care. So that's been my role, to develop and monitor and help the staff, the frontline staff, provide culturally... well, with the hopes of providing culturally safe and relevant services. For example, in our way of functioning, we focus on just getting to know the people in the school. So not rushing to do assessments, not rushing to get paperwork done, but again, emphasizing the importance of that relationship building with the communities, and setting up the conditions to make that possible.

Cultural safety is an evolving concept that is first and foremost a moral imperative in practice. How this concept is defined, practiced and experienced depends on one's theoretical framework, positionality, values, identified community and context. Cultural safety can be understood from a therapeutic-medical perspective as a guiding approach to promoting healing with Indigenous children and families, and its meaning also shifts when adhering to a socio-political framework of Indigenous rights to self-determination. Some of the consulting practitioners spoke of what they deemed to be culturally safe practice without knowledge of the term 'Cultural Safety.' Whereas other consultants expressed an interest in changing the term from the way it is currently framed in healthcare.

The term 'cultural safety' wouldn't have been my first choice. I know that at least there is some definitions of it in the literature and so some consensus can be formed around it. I conceptualize it as not being the final product but a step along the way—an ongoing journey that goes well beyond cultural safety and beyond cultural integrity. I don't know what the terminology would be. I still find that cultural safety is still defined from and for the perspective of the clinician, as something that the clinician has to provide. What if there's some way of including the patient in that term? Like cultural alliance? Cultural—I don't know... cultural synergy... some way where they meet together on a level relationship with mutuality. English is a fluid language. I've lived through people being called Indians, Natives, First Nations people, Aboriginal was popular for a while there, and now we have Indigenous. But we haven't changed an awful lot about what's going on. I have an inherent distrust of the appropriate wording if there's no background to that change in wording.

'Culture' is too often used as an inaccurate euphemism to avoid naming structural violence and systemic racism, and 'safety' can be limited to avoiding risks and harms rather than truly engaging in respectful approaches and relationships. We listened deeply to the stories and experiences of practitioners who work within oppressive structures in partnership with Indigenous families and communities that are not their own. They are committed to making mistakes, stumbling and crying along the way, and daring to speak up. They do this because the joys of becoming part of an Indigenous community is a life choice and worldview of what is about ethics and equity, rather than a career. We came to understand that 'culture' is everything resilient and wise about Indigenous traditions, survival, and revitalization; whereas 'safety' is about no longer perpetuating colonial oppression and finding ways to address and redress the damage, together.

The big thing is that these are not practice skills that are somehow unique to working within the Indigenous community. They are practice skills that you have to have to work within any community if you really want to do the job you thought you're doing. It really sounds very simple, right? You acknowledge the power differential and structural violence, learn the colonial history of the community and the family, understand and participate in the community and context of the child, build relationships and trust, meet yourself where you're at—even if that's uncomfortable—critique and go against your western training, adapt and do the rehab assessment in line with the family's values and priorities, learn about Indigenous ways of healing, and meld all these together somehow, and then do a good job of explaining and intervening and advocating. Right? How simple is that?



FINAL REFLEXIVE NOTES
&
GRATITUDE





Listening to the consultants and writing this guide unfolded during the confluence of a global pandemic and worldwide protests against systemic racism and oppression.

These events certainly supported our ability and moral commitment to see and name these, while also being honest about the context and scope of this project. The metaphor of a lifelong voyage emerges from the consultants' stories and the fact that each was on a different part of the journey with their range of years of experiences. This guide would look quite different if we only focused on experts, and it would certainly be different from the perspective of Indigenous families and community members. Alongside this is the fact that the five students conducting the research—Alexa, Daisy, Hilary, William and Naomie—are all personally and professionally committed to valuing justice, and continually engaged in learning about anti-oppressive approaches. They are at the start of their careers, so the concern with 'what will it take to get there?' is forefront for each of them.

The guide was finalized by Hiba as project supervisor while sitting in her father's office in Lebanon, a few weeks following an explosion attributed to decades of government corruption, economic collapse, and ongoing geopolitical colonial impacts. This led to the final 'ghost writing' style of the guide, to remain true to the 'on the ground' experience in structural violence. This includes leaving things unsaid, uninterpreted, and unfinished; and therefore, the responsibility lies with the readers to continue deepening their understanding and ethical commitments.

We offer our gratitude to our community partners, Jessica and Aimee, for trusting us with this work. It was a time investment on their part during a period of transition in their services as well as the pandemic. We are honored to have learnt from the wisdom of the consulting practitioners and we thank everyone who helped spread the word about this project. We acknowledge Leah Dolgoy, Director of Allied Health Services at the Cree Board of Health and Social Services of James Bay (CBHSSJB), whose commitments to reconciliation facilitates the relationship between McGill University and the rehabilitation and disability services at the CBHSSJB.

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CITATIONS

1. Jackson, M., *Politics of Storytelling: Violence, Transgression and Intersubjectivity*. 2002, Copenhagen, Denmark: Museum Tusulanum Press.
2. Mattingly, C., *Narrative Matters*, in *The Paradox of Hope: Journeys Through a Clinical Bordeland*. 2010, University of California Press: Los Angeles. p. 27-53.
3. Rhodes, C., *Ghostwriting Research: Positioning the Researcher in the Interview Text*. *Qualitative Inquiry*, 2000. 6(4): p. 511-525.
4. Mattingly, C., *The paradox of hope. Journeys through a clinical borderland*. 2010, Los Angeles, CA: University of California Press.
5. Denborough, D. *Recent developments in narrative responses to social suffering: Narrative therapy charter of story-telling rights*. 2018; Available from: www.dulwichcentre.com.au.
6. Alameddine, R., *The Hakawati*. 2008, Canada: Bond Street Books.
7. Marrone, S., *Understanding barriers to health care: a review of disparities in health care services among indigenous populations*. *International Journal of Circumpolar Health*, 2007. 66(3): p. 188-198.
8. Smylie, J. and M. Anderson, *Understanding the health of Indigenous peoples in Canada: key methodological and conceptual challenges*. *Canadian Medical Association Journal*, 2006. 175(6): p. 602-605.
9. Truth and Reconciliation Commission of Canada, *Honouring the Truth, Reconciling for the Future. Summary of the Final Report of the Truth and Reconciliation Commission of Canada*. 2015, Author: Ottawa, ON.
10. Razack, S.H., *Dying from Improvement: Inquests and Inquiries into Indigenous Deaths in Custody*. 2015, Toronto, ON: University of Toronto Press.
11. Tang, S.Y. and A.J. Browne, *'Race' matters: racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context*. *Ethnicity and Health*, 2008. 13(2): p. 109-127.
12. Tuck, E., *Suspending damage: A letter to communities*. *Harvard Educational Review*, 2009. 79(3): p. 409-427.
13. Smith, L.T., *Decolonizing methodologies. Research and Indigenous peoples*. 2nd edition. 2012, Dunedin, New Zealand: Otago University Press.
14. Greenwood, M., *Determinants of Indigenous Peoples Health in Canada: Beyond the Social*. 2015, Toronto, Ontario: Canadian Scholars' Press.

15. Meijer drees, L., *Healing History: Stories from Canada's Indian Hospitals*. . 2012: University of Alberta Press.
16. Canada, G.o. Reducing the number of Indigenous children in care. 2020 [cited 2002 August 24]; Available from: <https://www.sac-isc.gc.ca/eng/1541187352297/1541187392851>.
17. Centennial College, *Our Stories. First Peoples in Canada*. n.d.: Toronto, ON. p. <https://ecampusontario.pressbooks.pub/indigstudies/>.
18. Canada, T.a.R.C.o., *Honouring the truth, reconciling for the future: summary of the final report of the Truth and Reconciliation Commission of Canada*. 2015, Truth and Reconciliation Commission of Canada: Winnipeg, Manitoba.
19. Richarson, S. and T. Murphy, *Bringing reconciliation to healthcare in Canada- wise practices for healthcare leaders*. 2018, HealthCareCan: Toronto, Ontario.
20. Canada, T.a.R.C.o., *Truth and reconciliation commission of Canada: Calls to action*. 2015: Winnipeg, Manitoba.
21. Corporation, C.B. *Beyond 94: Truth and reconciliation in Canada*. 2019 [cited 2020; Available from: <https://newsinteractives.cbc.ca/longform-single/beyond-94?cta=22>.
22. United Nations, *United Nations Declaration on the Rights of Indigenous Peoples* D.o.E.a.S. Affairs, Editor. 2007.
23. Justice Sinclair, M., *Truth and Reconciliation chair urges Canada to adopt UN declaration on Indigenous Peoples*, in *The National*, P. Mansbridge, Editor. 2015, CBC: Ottawa, ON.
24. Polaschek, N.R., *Cultural safety: a new concept in nursing people of different ethnicities*. *J Adv Nurs*, 1998. 27(3): p. 452-7.
25. Ramsden, I., *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*, in *Department of Nursing*. 2002, Victoria University of Wellington.
26. Papps, E. and I. Ramsden, *Cultural safety in nursing: the New Zealand experience*. *Int J Qual Health Care*, 1996. 8(5): p. 491-7.
27. Glenn, E.N., *Settler Colonialism as Structure: A Framework for Comparative Studies of U.S. Race and Gender Formation*. *Sociology of Race and Ethnicity*, 2015. 1(1): p. 52-72.
28. Gerlach, A. *Exploring socially-responsive approaches to children's rehabilitation with Indigenous communities, families, and children*. 2018.

30. Hart-Wasekeesikaw, F. Cultural competence and cultural safety in nursing education - A framework for first nations, inuit and métis nursing.pdf. 2009.
31. Ball, J., Promoting equity and dignity for Aboriginal children in Canada. Institute for Research on Public Policy, 2008. 14(7).
32. Gerlach, A.J., A critical reflection on the concept of cultural safety. *Can J Occup Ther*, 2012. 79(3): p. 151-8.
33. Health, W.C.f.A., *Creating cultural safety - looking at Ottawa*. 2014: Vanier, Ontario.
34. Ball, J. and P. Janyst, Screening and assessment of Indigenous children: Community-university partnered research findings. *Early Childhood Development Intercultural Partnerships*, 2008.
35. D'Aprano, A.L., J.R. Carapetis, and R. Andrews, Trial of a developmental screening tool in remote Australian Aboriginal communities: a cautionary tale. *J Paediatr Child Health*, 2011. 47(1-2): p. 12-7.
36. Bombay, A., K. Matheson, and H. Anisman, The intergenerational effects of Indian Residential Schools: implications for the concept of historical trauma. *Transcult Psychiatry*, 2014. 51(3): p. 320-
37. Brave Heart, M.Y.H., *Wakiksuyapi: Carrying the historical trauma of the Lakota*. *Tulane Studies in Social Welfare*, 2000. 21-22: p. 245-266.
38. Restall, G., A. Phenix, and K. Valavaara, Advancing reconciliation in scholarship of occupational therapy and Indigenous Peoples' health. *Can J Occup Ther*, 2019. 86(4): p. 256-261.
39. Kovach, M., Indigenous methodologies: Characteristics, conversations, and contexts. *The Canadian Geographer / Le Géographe canadien*, 2012. 56(2): p. 292-293.
40. Carlson, E., *Anti-colonial methodologies and practices for settler colonial studies*. *Settler Colonial Studies*, 2017. 7(4): p. 496-517.
41. Kinsella, E.A. and G.E. Whiteford, Knowledge generation and utilisation in occupational therapy: towards epistemic reflexivity. *Australian Journal of Occupational Therapy*, 2009. 56(4): p. 249-258.
42. Davidson, L., *Living outside mental illness: Qualitative studies of recovery in schizophrenia*. *Living outside mental illness: Qualitative studies of recovery in schizophrenia*. 2003, New York, NY, US: New York University Press. xii, 227-xii, 227.
43. Leavy, P., Social research and the creative arts. An introduction, in *Method Meets Arts. Arts-Based Research Practice*, P. Leavy, Editor. 2009, The Guilford Press: New York. p. 1-24.

44. Butler-Kisber, L., Collage as inquiry, in *Handbook of the arts in qualitative research: Perspectives, methodologies, examples and issues*, G. Knowles and A. Cole, Editors. 2008, Sage: Thousand Oaks, CA. p. 265-276.
45. Kincheloe, J.L., Describing the bricolage: Conceptualizing a new rigor in qualitative research. *Qualitative Inquiry*, 2001. 7(6): p. 679-692.
46. Furlong, M. and J. Wight, Promoting "critical awareness" and critiquing "cultural competence": Towards disrupting received professional knowledges. *Special Issue: Australian indigenous social work and social policy*, 2011. 64(1): p. 38-54.
47. Downing, R., E. Kowal, and Y. Paradies, Indigenous cultural training for health workers in Australia. *Int J Qual Health Care*, 2011. 23(3): p. 247-57.
48. Kirmayer, L.J., Rethinking cultural competence. *Transcult Psychiatry*, 2012. 49(2): p. 149-64.
49. Elvidge, E., et al., Cultural safety in hospitals: validating an empirical measurement tool to capture the Aboriginal patient experience. *Aust Health Rev*, 2020. 44(2): p. 205-211.
50. Gottlieb, L., *Strengths-Based Nursing Care: Health And Healing For Person And Family*. 2003, New York, United States of America: Springer Publishing Company.
51. Wood, P.J. and M. Schwass, Cultural safety: A framework for changing attitudes. . *Nursing Praxis in New Zealand*, 1993. 8: p. 4-15.
52. Nursing Council of New Zealand, *Guidelines for cultural safety, the Treaty of Waitangi, and Maori health in nursing and midwifery education and practice*. 2005, Author: Wellington, NZ.
53. Smith, A., Heteropatriarchy and the Three Pillars of White Supremacy, in *The Colour of Violence: The Incite! Anthology*, Incite!, Editor. 2006, South End Press: Cambridge, Mass.
54. Jones, R., et al., Educating for Indigenous Health Equity: An International Consensus Statement. *Acad Med*, 2019. 94(4): p. 512-519.
55. Bishop, A., Step 5: Becoming an Ally., in *Becoming an ally: Breaking the cycle of oppression*. 1994, Fernwood Publishing: Halifax.
56. Gibson, P.A., Extending the Ally Model of Social Justice to Social Work Pedagogy. *Journal of Teaching in Social Work*, 2014. 34(2): p. 199-214.
57. Barudin, J. and H. Zafran, Introduction to trauma-informed rehabilitation with Indigenous communities. *Physiotherapy Practice [Special issue: Indigenous Health]*, 2019. 9(5): p. 18-21.

58. Tuck, E. and K. Yang, W., Decolonization is not a metaphor. *Decolonization: Indigeneity, Education & Society*, 2012. 1(1): p. 1-40.
59. United Nations, *International Covenant on Economic, Social and Cultural Rights*, O.o.t.H. Commissioner, Editor. 1966, Author.
60. Harris, L.D. and J. Wasilewski, Indigeneity, an alternative worldview: four R's (relationship, responsibility, reciprocity, redistribution) vs. two P's (power and profit). *Sharing the journey towards conscious evolution. Systems Research and Behavioral Science*, 2004. 21(5): p. 489-503.
61. Braude, H.D., Human all too human reasoning: comparing clinical and phenomenological intuition. *The Journal of Medicine and Philosophy*, 2013. 38(2): p. 173-89.
62. Kirmayer, L.J., The cultural diversity of healing: meaning, metaphor and mechanism. *British Medical Bulletin*, 2004. 69: p. 33-48.
63. Gillborn, D., Rethinking white supremacy: Who counts in 'WhiteWorld'. *Ethnicities*, 2006. 6(3): p. 318-340.
64. Gulati-Partee, G. and M. Potapchuk, Paying Attention to White Culture and Privilege - A Missing Link to Advancing Racial Equity. *The Foundation Review*, 2014. 6(1): p. 25-38.
65. Kendi, I.X. *Why Standardized Tests Have Standardized Postracial Ideology*. American Association of University Professors, 2016. Nov-Dec.
66. Rosales, J. *The Racist Beginnings of Standardized Testing*. NEA Today Magazine, 2018.
67. Ahmed, S., *Strange encounters. Embodied others in post-coloniality*. *Transformations: Thinking through feminism*, ed. M. McNeill, L. Pearce, and B. Skeggs. 2000, London, UK: Routledge.
68. Coulthard, G., *Red Skin, White Masks: Rejecting the Colonial Politics of Recognition*. 2014, Minneapolis: University of Minnesota Press.
69. Holmes, D., et al., Deconstructing the evidence-based discourse in health sciences: truth, power and fascism. *Int J Evid Based Healthc*, 2006. 4(3): p. 180-6.
70. Kirmayer, L.J., et al., Rethinking Resilience From Indigenous Perspectives. *The Canadian Journal of Psychiatry*, 2011. 56(2): p. 84-91.
71. Gerlach, A.J., A.J. Browne, and M. Greenwood, Engaging Indigenous families in a community-based early childhood program in British Columbia, Canada: A cultural safety perspective. *Health & Social Care in the Community*, 2017. 25(6): p. 1763-1773.

72. Thibeault, R. and M. Hébert, Community-based rehabilitation, in *Foundations for practice in occupational therapy*, E.A.S. Duncan, Editor. 2012, Churchill Livingstone Elsevier: London, UK. p. 235-244.
73. Motta-Ochoa, R., et al. A matter of time: grappling with everyday ethical tensions at the confluence between policy and practice in a psychiatric unit. *Journal of Medical Ethics*, 2019. DOI: <http://dx.doi.org/10.1136/medethics-2019-105423>.
74. Nelson, A. and H. Allison, Relationships: the key to effective occupational therapy practice with urban Australian Indigenous children. *Occupational therapy international*, 2007. 14(1): p. 57-70.
75. Kleinman, A., *What really matters. Living a moral life amidst uncertainty and danger*. 2006, Oxford, UK: Oxford University Press.
76. Mattingly, C., In search of the good: Narrative reasoning in clinical practice. *Medical Anthropology Quarterly*, 1998. 12(3): p. 273-297.
77. Mattingly, C., Reading minds and telling tales in a cultural borderland. *Ethos*, 2008. 36(1): p. 136-154.
78. Mattingly, C., *Moral laboratories. Family peril and the struggle for a good life*. 2014, Oakland, CA: University of California Press.
79. Horrill, T., et al., Understanding access to healthcare among Indigenous peoples: A comparative analysis of biomedical and postcolonial perspectives. *Nursing inquiry*, 2018. 25(3): p. e12237-e12237.
80. Battiste, M., *Indigenous knowledge and pedagogy in First Nations education. A literature review with recommendations*, N.W.G.o.E.a.t.M.o.l.a.N.A.C. (INAC), Editor. 2012, Apamuwek Institute: Ottawa, ON.
81. Simpson, L., *Dancing on our Turtle's Back. Stories of Nishnaabeg Re-Creation, Resurgence and a New Emergence*. 2011, Winnipeg, MB: Kromar Printing.
82. Centre, K.C.H. *Trauma-informed: the trauma toolkit. A resource for service organizations and providers to deliver services that are trauma-informed 2013; 2nd:[Available from: http://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf*.
83. World Health Organisation, *WHO Traditional Medicine Strategy: 2014-2023*. 2013, WHO: Geneva.
84. Bartlett, C., M. Marshall, and A. Marshall, Two-Eyed Seeing and other lessons learned within a co-learning journey of bringing together indigenous and mainstream knowledges and ways of knowing. *Journal of Environmental Studies and Sciences*, 2012. 2(4): p. 331-340.
85. Simpson, L.B., Land as pedagogy: Nishnaabeg intelligence and rebellious transformation. *Decolonization: Indigeneity, Education & Society*, 2014. 3(3): p. 1-25.

APPENDIX 1

OVERVIEW OF RESEARCH METHODS

AIM

Explore culturally safe rehabilitation practices surrounding neurodevelopmental diagnoses in children and their families, within isolated Indigenous communities.

SPECIFIC OBJECTIVES

- 1 Identify the current assessments, screening tools, and evaluation practices of paediatric neurodevelopmental clinics that are established within/for Indigenous communities;
- 2 Understand how cultural safety is defined and applied in paediatric rehabilitation within/for Indigenous communities.

METHODOLOGY

Critical interpretative approach within an Anti-Colonial Research Framework.

METHODS

Qualitative interview-based study design.

CONSULTANT INCLUSION CRITERIA

Administrators (clinical advisors, team leaders, staff responsible for developing cultural safety training) and practitioners (community case managers, rehabilitation monitors, licensed clinicians (eg. OTs, PTs, SLPs, Social Workers, Physicians) working in and around rehabilitation in Indigenous communities for at least one year who had as many of the following characteristics as possible:

- 1 Working in Canada, Australia or New Zealand.
- 2 Working - or have worked - with Indigenous children with neurodevelopmental diagnoses.
- 3 Working within rural/isolated Indigenous communities.
- 4 French or English speaking.

EXCLUSION CRITERIA

- 1 Indigenous families and clients themselves.
- 2 Practitioners working within a northern or remote Indigenous setting by default due to lack of other professional opportunities or due solely for financial incentives.
- 3 Practitioners working for less than one year with Indigenous families.

RECRUITMENT PROCESS

Snowball sampling drawing on the research team's relationships and partnerships within Indigenous rehabilitation services and networks. Potential consultants were contacted via email and were provided with a letter outlining the goal of the project goals and study inclusion criteria. The first consenting consultants helped recruit additional interviewees or organizations.

SAMPLE

Consulting practitioners were mainly non-Indigenous settlers:

- 3 self-identified Indigenous
- 14 non-Indigenous

The majority work in occupational therapy:

- 11 occupational therapists
- 4 physiotherapists
- 1 speech & language pathologist
- 1 social worker

They had between 2-30+ years of directly relevant experiences.

DATA COLLECTION & MANAGEMENT

Interviews were conducted via Zoom using a semi-structured interview guide developed in collaboration with the Cree community partners. Interviews were audio-recorded and transcribed verbatim. Transcripts were immediately de-identified, with a pseudonym list kept with three password layers. Each researcher kept a reflexive journal from the beginning of the project to reflect on significant moments during the interviews, and on emerging awareness of their biases and assumptions.

DATA ANALYSIS

Data analysis involved multiple steps which were recursive and focused on depth of understanding:

- 1 Data immersion in the audio recordings and transcripts.
- 2 Reading transcripts and extracting themes in relation to the research objectives, with a focus on the consultants' significant experiences.
- 3 Interpreting and inter-relating the themes from transcripts using an anti-colonial framework that acknowledges the history of oppression.
- 4 Research team weekly reflexive dialogues about the emergent findings with detailed minutes.
- 5 Placing the themes in dialogue with cultural safety guidelines and position statements from both Indigenous and non-Indigenous sources; national, local and organizational guidelines; and scientific literature about emerging evidence on evaluation practices with Indigenous clients.
- 6 The themes were presented to community partners midway, and towards the end of the project, for resonance and utility.
- 7 An audit trail of decision-making was kept throughout.

PROJECT LIMITATIONS

The available literature on cultural safety is extensive. In this project, the literature was limited to salient guidelines and documents related to practice with Indigenous communities. The timeframe for data collection and analysis was restricted to May-August 2020, thereby curtailing interviews with additional consultants who wanted to share their stories. The sample was primarily composed of occupational therapists due to the relational nature of snowball sampling and the research team being situated in an occupational therapy program. It is also important to note that the values and ideas around cultural safety are from the perspectives of the consulting practitioners, not Indigenous families or community members—with the exception of Elder Debbie Cielen.

ETHICAL APPROVAL

McGill University Institutional Review Board Study Number: A00-E10-20A (20-02-046)

APPENDIX 2

APPREHENDING CULTURAL SAFETY

- Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why Cultural Safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health*, 18(1), 174. Doi:10.1186/s12939-019-1082-3
- Downing, R., Kowal, E., & Paradies, Y. (2011). Indigenous cultural training for health workers in Australia. *International Journal for Quality in Health Care*, 23(3), 247-257. Doi:10.1093/intqhc/mzr008
- Elvidge, E. B. A. P., Paradies, Y. P., Aldrich, R. M. P. H. P. F. F., & Holder, C. M. (2020). Cultural Safety in hospitals: validating an empirical measurement tool to capture the Aboriginal patient experience. *Australian Health Review*, 44(2), 205-211. Doi:<http://dx.doi.org/10.1071/AH19227>
- First Nations Health Authority. (2016). Creating a climate for change. <https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf>
- Fleming, T., Creedy, D. K., & West, R. (2019). Evaluating awareness of Cultural Safety in the Australian midwifery workforce: A snapshot. *Women and Birth*, 32(6), 549-557. Doi:<https://doi.org/10.1016/j.wombi.2018.11.001>
- Gerlach, A. J. (2012). A critical reflection on the Concept of Cultural Safety. *Canadian Journal of Occupational Therapy*, 79(3), 151-158. Doi:10.2182/cjot.2012.79.3.4
- Indigenous Health. (2017). *Cultural Safety: respect and dignity in relationships*. Prince George, BC: Northern Health.

- Kirmayer, L. J. (2012). Rethinking cultural competence. In: Sage Publications Sage UK: London, England.
- Laverty, M., McDermott, D. R., & Calma, T. (2017). Embedding cultural safety in Australia's main health care standards. *The Medical Journal of Australia*, 207(1), 15-16.
- McGough, S., Wynaden, D., & Wright, M. (2018). Experience of providing Cultural Safety in mental health to Aboriginal patients: A grounded theory study. *International Journal of Mental Health Nursing*, 27(1), 204-213.
- Milne, T., Creedy, D. K., & West, R. (2016). Development of the Awareness of Cultural Safety Scale: A pilot study with midwifery and nursing academics. *Nurse Education Today*, 44, 20-25.
Doi:<https://doi.org/10.1016/j.nedt.2016.05.012>
- National Aboriginal Health Organization. (January 31st, 2006). Fact sheet : Cultural Safety
<https://www.aht.ca/images/stories/ACSI/NAHO-Cultural-Safety.pdf>
- Papps, E., & Ramsden, I. (1996). Cultural Safety in Nursing: The New Zealand experience. *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care / ISQua*, 8, 491-497. Doi:10.1093/intqhc/8.5.491
- Ringer, J. (2017). Cultural Safety and engagement: Keys to improving access to care. Paper presented at the Healthcare Management Forum.
- Rowan, M. S., Rukholm, E., Bourque-Bearskin, L., Baker, C., Voyageur, E., & Robitaille, A. (2013). Cultural competence and Cultural Safety in Canadian schools of nursing: A mixed methods study. *International Journal of Nursing Education Scholarship*, 10(1), 1-10.
- Ryder, C., Mackean, T., Ullah, S., Burton, H., Halls, H., McDermott, D., & Edmondson, W. (2019). Development and validation of a questionnaire to measure attitude change in health professionals after completion of an aboriginal health and cultural safety training programme. *The Australian Journal of Indigenous Education*, 48(1), 24-38.

APPENDIX 3

GLOSSARY OF TERMS

The following is a list of core terms for culturally safer practice. Practice researching, defining and applying these in your daily practice.

ANTI-COLONIAL	POSITIONALITY
ANTI-RACISM	PRIVILEGE
ASSIMILATION	RECONCILIATION
BIASES (IMPLICIT)	REFLEXIVITY
COLONIZER / COLONIZATION	RELATIONSHIP
CRITICAL REFLEXIVITY	REGARDFUL CARE
CULTURAL AGILITY	RELATIONSHIP-CENTERED CARE
CULTURAL HUMILITY	SELF-DETERMINATION
CULTURAL SAFETY	SETTLER
DECOLONIZATION	SOCIAL IDENTITY / LOCATION
EMPOWERMENT	STRUCTURAL VIOLENCE
EQUITY (HEALTH, SOCIAL)	TRAUMA
EUROCENTRIC	HISTORICAL, COLLECTIVE
GENOCIDE	MULTI/INTER/TRANS-GENERATIONAL
HARM	TREATY
LAND CLAIM	TWO-EYED SEEING
NEOLIBERALISM	UNSETTLING
OPPRESSION	VULNERABILITY
POWER / POWER IMBALANCE	WHITE SUPREMACY
	WHITE FRAGILITY

WORKBOOK

TRAVEL NOTES

This workbook is about exploring your own positionality and experiences of becoming culturally safer as you enter into Indigenous communities and world views. It is meant to be completed after reading "Stories of Paediatric Rehabilitation Practitioners with/in Indigenous Communities: A Guide to Becoming Culturally Safer." The workbook follows the themes narrated in the guide. Within each section is a short summary of the theme, followed by questions and exercises that you can use to guide your reflections and actions.

The workbook can be used as a map or a journal. You can narrate your meaningful experiences in written or audio format at the end of your day, then use the questions to untangle them. You can also go through the workbook systematically to reflect on your everyday. Remember that although these questions are individual and personal, your experience is unfolding within structures that are violent and oppressive.

Be mindful of what is, and what isn't, within your sphere of ability to effect change.

DEFINING CULTURAL SAFETY

Write down your current understanding of cultural safety in your own words, and what you intend your culturally safe practice to be. Return to your statement regularly, adding, amending, and changing your understanding along the way.

EMBARKING ON THE JOURNEY

Everyone starts the journey of becoming culturally safer at a different place, bringing in their own experiences, values, cultures, and ideas into where they are positioned relative to the communities they work with. Practitioners hold different intentions for entering and working in and for Indigenous communities, and these intentions tend to shift as practitioners learn more about themselves, and the communities. This shift can be disorienting.

What are your intentions for working in and for Indigenous communities?

What do these intentions tell you about yourself, and what you value?

How much do you know about colonial history in Canada?

What about the colonial history of the communities you are entering?

How have you gotten to know the communities you are working with?

Where did that information come from?

Are there any voices missing from this education?

Have you faced any logistical barriers that impact the services you provide to the community[ies] with whom you work?

What are they?

Where do these barriers come from?

How have you solved or avoided these barriers?

Are there any tensions between your values and the values held by the community[ies] with whom you work?

Are there priorities that seem to differ between you and the community[ies]?

Where do these differences come from?

What do you do when these tensions arise?

PRACTICAL EXERCISES

Engage with an Indigenous-created documentary, movie, podcast, TV series, book, poetry or blog. Subscribe to local Indigenous newsletters and social media. Ask someone local for recommendations.

Use a map of the territory to begin pinpointing key community locations and what historical events took place and where.

AN UNSETTLING JOURNEY

The journey of cultural safety is unsettling. It unsettles ideas of history, identity as a citizen or immigrant to Canada, and understandings of the role of healthcare and rehabilitation. The initial barriers that professionals face help them to see the continued violence of colonialism. The unsettling process continues as practitioners become aware of their own complicity and active role in that violence. This process is uncomfortable and is a necessary step towards finding a new path.

How do you identify yourself?

Do you think this is how you are perceived by Indigenous communities?

How well do you grasp the policies, governing, and funding structures in your organization, setting, or territory?

Reflect on moments in your practice that felt unsettling or uncomfortable.

Where were you? What did you see? What happened?

Why did it happen?

What does this say about your values? Beliefs?

What can you take away from this particular encounter to inform your future practice?

How do you manage feelings of discomfort in your practice?

How do you interpret this discomfort?

What do the services mean to the families you work with?

What do the services represent to them?

How might you find out?

How have your understandings of what your services mean to families changed?

What are some of the ways that colonialism and white supremacy show up in your community?

In your healthcare practices?

Do you know the history of your profession in relation to colonization and in Indigenous communities?

PRACTICAL EXERCISES

Write, draw, paint, or express in any way your emotions and experiences. This can perhaps be a puzzle of the pieces you are trying to fit together, a scribble of rage, or speaking into your phone's voice memo while walking outdoors. It can be a representation or an expression. You can also be in dialogue with someone you trust.

Complete some critical readings from the reference list in the guide that focus on systemic racism and white supremacy.

Review the signs and symptoms of vicarious trauma and compassion fatigue, and identify an accessible resource for yourself, in case the need should arise.

BUILDING RELATIONSHIPS ON, AND FOR, THE JOURNEY

Building relationships is an integral to working with Indigenous children and families. As practitioners we need to work to create a safe space where families are able to share their experiences. Relationships can take years to build and require consistency and effort on our part. We need to show vulnerability and interact as person to person rather than clinician to patient. In doing so, we can move towards becoming part of the community.

How are relationships built in your culture(s)?

What comes naturally to you?

How much time are you usually able to take with each patient?

Has this been enough to foster a relationship?

How do you try to create a safe space for your clients?

How do you know when a client is feeling safe?

What are some ways in which you could work on becoming part of the community?

Reflect on what you have done so far;

How has this affected your practice?

How is this shifting your understanding of your role?

What activities or events might you participate in to foster relationships?

In your experience, what does it mean to 'meet someone where they are at'?

Think of a specific moment you were able to do so;

What does this moment reveal to you?

Have you been able to show vulnerability to your clients?

How were you able to do so?

What was the response from your client?

What blocks you from being vulnerable?

What is your own cultural understanding of vulnerability?

Reflect on where you are now.

What are some concepts that you are struggling with or that you have come to terms with?

How do you cultivate compassion for yourself?

PRACTICAL EXERCISES

Participate in a community event or ceremony. Make friends.

Create a visual-social map of who-is-who in the community: How they are related, who people go to for decisions or guidance. Beyond an organigram of your organization, this will help you get situated for relationship-building.

UNCOVERING PATHS TOWARDS RECONCILIATORY PRACTICES

Practitioners need to find new paths and ways to practice that are move against and beyond the values of White supremacy in the healthcare disciplines. At minimum, these paths foster respectful practices. At best, by uncovering these paths, practitioners engage in honoring Indigenous people's right to self-determination. There are three overlapping paths that practitioners find on the journey. The first is to go beyond reflection and actively resist the harmful ideologies of White supremacy and neoliberalism within healthcare and rehabilitation. On the trail, therapists need to identify practice frameworks that are developed by and for Indigenous communities. Finally, there are practical everyday strategies that minimize harm, foster respect and relationships and push against colonialism.

What does professionalism mean to you?

Who are your role models?

Who do you aspire to be like in your career?

What does it mean to you to be a professional in your discipline?

Has that changed since you began working with Indigenous communities and children?

Who do you seek guidance from?

What does this reveal about whose knowledge you consider legitimate?

Who feels safe to you?

Do you have anyone in the community to help you navigate working in an Indigenous context, someone who knows the community, knows the families?

Identify ways that standards and processes set by your profession and organization can:

Limit your ability to build relationships;

Keep you from connecting with families, communities, children;

Stop you from becoming part of the community;

Pose a risk to you in terms of auditing.

How can you engage in activism and change?

What does your organization or the community do?

What can you contribute?

What data can you collaboratively collect and for which purposes?

Are you involved in national networks?

What can you contribute?

What data can you collaboratively collect and for which purposes?

Are you involved in national networks?

Do you reframe your practice to align with Indigenous teachings and ways of

What can you do differently to share more power?

What might be difficult for you when thinking about letting go of some of the power you hold?

What is the difference between empowerment and self-determination in your practice?

What assessments do you use?

Why are you using them – whose agenda are you fulfilling?

Is there any way they could potentially be causing harm - either from the assessment process itself or the results and how they're perceived?

Has the community / family been consulted on the need and impact of the assessment?

How do you write your reports?

Who do you write your reports for?

How would families feel if they were to read your reports?

What are the consequences of your reports?

PRACTICAL EXERCISES

Take one of your chart notes: Re-write it jargon-free and with a critical eye. Include your (mis) interpretations and actions in there. Apply your understanding of colonial history and trauma to document the specific situation. Include strengths. Identify your next step with the family. Include your own actions in intervention planning.

THE HEART & JOY OF THE JOURNEY

Working with/in Indigenous communities is a meaningful life-journey.

Reflect on a challenging experience in your practice

What has helped you to continue to move forward?

What have been some of your positive experiences while working with Indigenous children and families?

What made these experiences stand out?

What are some of the reasons that encourage you to continue this journey?

How have Indigenous teachings and community enriched your perspective?

PRACTICAL EXERCISES

At the beginning or end of your workday, give thanks.

WIDENING HORIZONS

Revisit your initial definition and understanding of cultural safety.

What skills do you have to implement your understanding?

What supports and resources do you have?

Where does your definition lie in relation to the:

Individual vs organizational;

Medical-therapeutic vs political;

Harm avoidance vs redressing wrongs;

Definition of cultural safety that Indigenous families share with you.

PRACTICAL EXERCISES

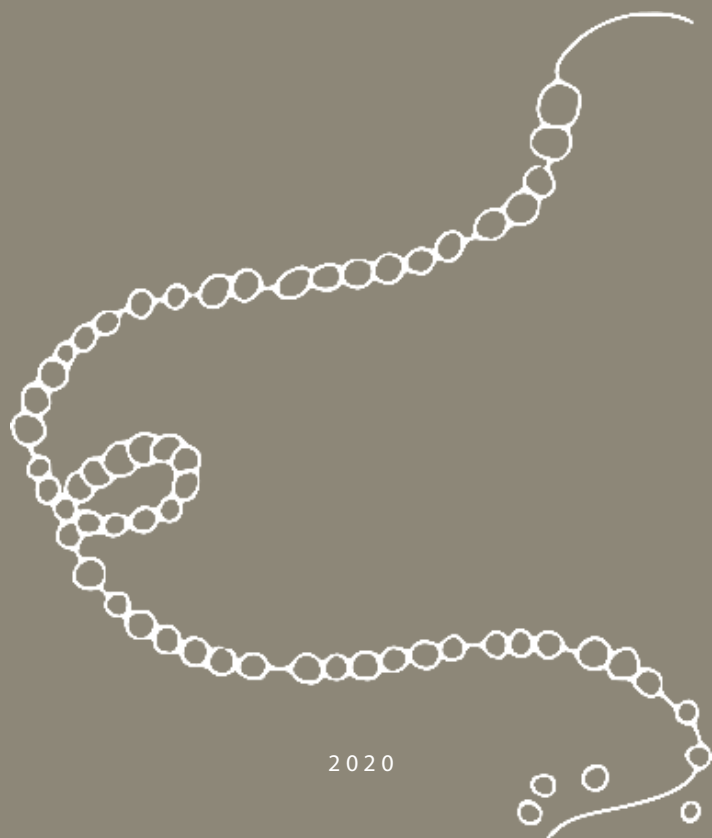
Write or tell the story of becoming part of the community you are working with, or brainstorm a map of words that you associate with cultural safety (skills, values, experiences, contexts, etc.). What does this reveal about your definition of cultural safety? Is your horizon of understanding wide enough?

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