ACOTRO
ASSOCIATION OF CANADIAN OCCUPATIONAL THERAPY REGULATORY ORGANIZATIONS

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ASSOCIATION CANADIENNE DES ORGANISMES DE RÉGLEMENTATION EN ERGOTHÉRAPIE

ACOTRO's 2025 Annual eLearning Module

Advancing Culture, Equity and Justice in Occupational Therapy Practice

Introduction

Welcome to the 2025 national eLearning module: Advancing Culture, Equity and Justice in Occupational Therapy Practice.

We invite you to learn alongside one another as we explore cultural humility and equity in occupational therapy practice. Each of us is at a unique place in this personal and professional journey and this module may be a starting point for some or an extension for others. As our awareness and understanding evolves, incorporating humility and culturally safer practice is a lifelong endeavour. OTs have told us in a variety of ways that this topic is one they want to learn more about. This module is one small step towards advancing collective change.

While taking part in this module, each of us is responsible for our own learning. We encourage you to approach this with a spirit of curiosity and an openness to think and do differently. As you move through the module, we invite you to pause and consider the following questions: *How can this learning apply to my practice? What do I need to unlearn—information, assumptions or actions?*

We have approached this subject with respect, humility and sensitivity. Given the nature of this topic, the content may raise emotions for occupational therapists who have experienced inequities or harm. We acknowledge how difficult this can be to explore. Please draw on trusted supports to help you journey through this topic.

You are invited to share comments in a survey after completing the module.

Module sections

The module is organized into four main sections. Section 1 provides an overview, Section 2 describes concepts and data, Section 3 highlights strategies for advancing change and Section 4 applies this learning using scenarios specific to occupational therapy.

Section 1: Overview

- Learning outcomes
- How the module was developed
- A national perspective
- Competencies for Occupational Therapists in Canada
- What to expect

Learning outcomes

By the end of this module, OTs will:

- Better understand Domain C of the *Competencies for Occupational Therapy Practice in Canada* ("the Competencies"), and important concepts related to culture, equity, and justice in occupational therapy practice.
- Gain insight into the vast diversity across Canada's population and how this diversity relates to health equity and outcomes.
- Understand and be able to apply individual and collective strategies for culturally safer and equitable practice to real life occupational therapy situations.

How the module was developed

- This module was created by *occupational therapists, for occupational therapists*.
- Writers consulted with OTs and advisory groups representing Indigenous and other equity perspectives.
- We also asked for advice from OTs with specific knowledge in the area of culture, equity and justice.
- These valuable contributions from the profession are paired with actual experiences from clients and caregivers of occupational therapy service who bring diverse lived experience. Their input was collected using a survey and has been included.
- The module also draws on literature and other resources, including:
- The *Competencies for Occupational Therapists in Canada* (ACOTRO, ACOTUP, & CAOT, 2021/2024); and
- The Joint position statement—Toward Justice: Enacting an intersectional approach to social accountability in occupational therapy (CAOT, ACOTUP, & ACOTRO, 2024).

A national perspective

The public wants occupational therapy services that are safe, effective and ethical. As regulators that oversee the profession across the country, providing resources to support cultural humility and culturally safer practices serves this public need.

While there are certainly local nuances across jurisdictions, this topic has widespread relevance throughout Canada. For this reason, regulators and other occupational therapists from across the country have contributed to this shared work so we can learn together, as 'centering equity must be a collective endeavour' (Kania et al., 2021).

The Competencies were updated to acknowledge systemic racism and oppression in Canada.

Domain C, Culture, Equity and Justice sets out expectations for occupational therapists to:

C1: Promote equity in practice

C2: Promote anti-oppressive behaviour and culturally safer, inclusive relationships

C3: Contribute to equitable access to occupational participation and occupational therapy

Competencies for Occupational Therapists in Canada

The competent occupational therapist is expected to:

C1. Promote equity in practice

C 1.1 Identify the ongoing effects of colonization and settlement on occupational opportunities and services for Indigenous Peoples.

C1.2 Analyse the effects of systemic and historical factors on people, groups, and their occupational possibilities.

C1.3 Challenge biases and social structures that privilege or marginalize people and communities.

C1.4 Respond to the social, structural, political, and ecological determinants of health, well-being, and occupational opportunities.

C1.5 Work to reduce the effects of the unequal distribution of power and resources on the delivery of occupational therapy services.

C1.6 Support the factors that promote health, well-being, and occupations .

C2. Promote anti-oppressive behaviour and culturally safer, inclusive relationships

C2.1 Contribute to a practice environment that is culturally safer, anti-racist, anti-ableist, and inclusive.

C2.2 Practise self-awareness to minimize personal bias and inequitable behaviour based on social position and power.

C2.3 Demonstrate respect and humility when engaging with clients and integrate their understanding of health, well-being, healing, and occupation into the service plan.

C2.4 Seek out resources to help develop culturally safer and inclusive approaches.

C2.5 Collaborate with local partners, such as interpreters and leaders.

C3. Contribute to equitable access to occupational participation and occupational therapy

C3.1 Raise clients' awareness of the role of and the right to occupation.

C3.2 Facilitate clients' participation in occupations supporting health and well-being.

C3.3 Assist with access to support networks and resources.

C3.4 Navigate systemic barriers to support clients and self.

C3.5 Engage in critical dialogue with other stakeholders on social injustices and inequitable opportunities for occupations.

C3.6 Advocate for environments and policies that support sustainable occupational participation.

C3.7 Raise awareness of limitations and bias in data, information, and systems.

About the module

*The module **does**:*

- focus on real occupational therapy scenarios as the way to build awareness and application to practice;
- include reflective questions to deepen personal and professional understanding;
- apply to OTs across locations and professional roles; and
- introduce several concepts related to culture and equity, with the understanding that terminology and experiences are evolving; incorporating humility into practice is a lifelong endeavour.

*The module does **not**:*

- represent the extensive research or academic work that has been done on this complex topic.

The topic is broad, and the module is narrow. Other concepts and literature exist in this space and OTs have contributed to this foundational work. We thank you.

For those that would like to delve deeper, check out the References section at the end of this document.

What to expect

While research and concepts are woven throughout the module, this resource aims to increase awareness of cultural humility in occupational therapy primarily by using examples from diverse practice areas. Regardless of the role, the intent is that therapists, both with a clinical and non-clinical nature of practice, can see themselves in the examples and are more likely to apply the learning directly to their daily work. The format encourages self-reflection through interactive opportunities for individual on-the-spot insights.

The Reflective Question Guide can be used to assist with self-reflection as you move through the module (or to reflect at a later date) and encourage peer discussions.

Your voices

The scenarios are real and have been provided by OTs both individually and through focus groups. They shared their experiences and reflections to demonstrate how health inequity is perpetuated and ways it can be disrupted.

Client voices

Throughout the module, you'll also see quotes from clients and their caregivers, who were surveyed during the development process. This group shared personal stories of inclusion and safety as well as comments to inspire reflection and change. These insights formed the foundation for the strategies described later in this module.

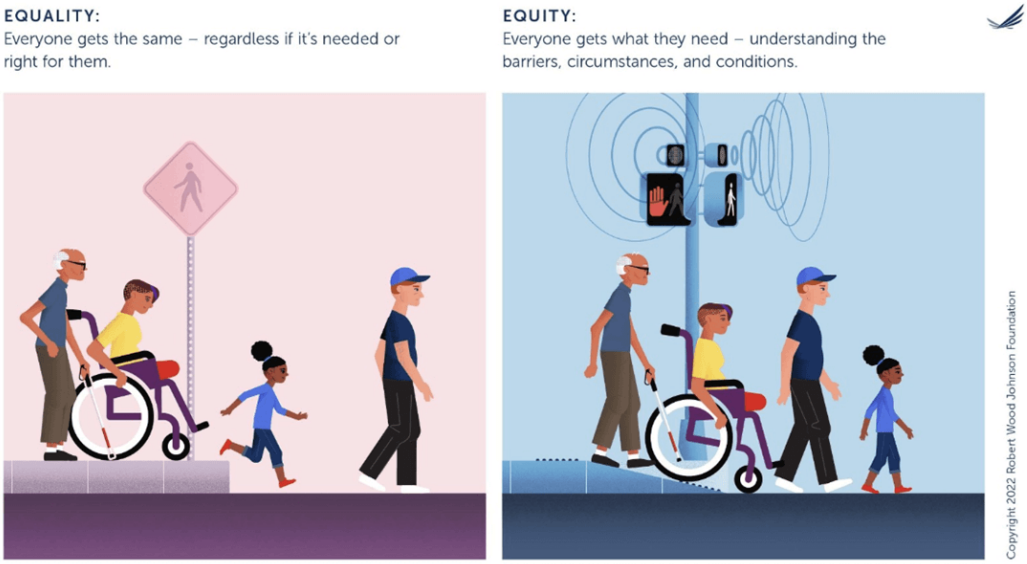
Section 2: Concepts and Data

- Equity
- Culturally safer practice
- Cultural humility
- Snapshot of Canada's diversity
- Health inequities
- Intersectionality
- Social location
- Power and privilege
- Bias as a barrier

Concepts

While other concepts exist, the terms *equity, culturally safer practice, and cultural humility* are used throughout this module.

Equity is different from equality



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Equity is different from equality.

Equality means everyone has the same resources and opportunities.

Equity allocates resources and opportunities based on each person's circumstances, so that they can achieve equal outcomes.

We need to take an equity approach because so many barriers to equality still exist in our society (ACOTRO, ACOTUP, & CAOT, 2021/2024).

Note: These are common definitions of equality and equity. In Canada, courts have defined equality to mean substantive equality. This means that, in Canada, a law, policy or action can be found to be discriminatory (and contrary to human rights legislation or section 15 of the Charter of Rights and Freedoms) even if the law/policy/action treats everyone the same.

An introduction to… culturally safer practice

Culturally 'safer' is a refinement to the concept of 'cultural safety'.

OTs remain aware that they are in a position of power in relation to clients. They are mindful that many marginalized people – Indigenous people for example – have a history of serious mistreatment in healthcare settings. These clients may never feel fully safe.

Occupational therapists can encourage those who receive services to determine what they consider to be safe and support them in drawing strength from their identity, culture, and community.

Although cultural safety is unlikely to be fully achievable, it is important to continue working towards it (ACOTRO, ACOTUP, & CAOT, 2021/2024).

An introduction to… cultural humility

Cultural humility assumes a "lifelong, learning-oriented approach to working with people with diverse cultural backgrounds and a recognition of power dynamics in health care" (Tervalon & Murray-Garcia, 1998 as cited in Agner, 2020).

There is:

- "an emphasis on learning rather than knowing,
- recognition of a client's cultural perspectives as equally valid, and
- critical reflection on how systemic issues and power differences affect health care" (Agner, 2020).

Cultural humility

With cultural humility, OTs are not expected to know the details of a particular culture but instead be curious and ask open questions that help to understand and respond to a client's view on their health, wellness, family and roles.

Asking broader questions is also central to cultural humility. Insights can help to identify and "unlearn" worldviews and behaviours that are systemically harmful to particular groups (Beagan, 2015).

What kind of questions further cultural humility in our OT work? Questions like…

- **About Access:** "How could our clinic hours impact the access to services for some clients?", "Do the hours of operation advantage some clients and disadvantage others?"
- **About the Setting:** "What does our physical space say about our belief of what healthcare should look like?", "Do the surroundings and supplies reflect the populations served?".

How can I apply these concepts in my practice?

Let's start by learning a bit about Canada's diverse population.

Snapshot of Canada's diversity

Canada is made up of diverse peoples, in fact there are **people from more than 450 ethnic or cultural origins** in Canada.

Let's take a quick look at details related to diversity in our population, reported by Statistics Canada.

Note: It is recognized that there may be challenges in how this population data is collected. These data sources are being used as a starting point for understanding the diversity across Canada.

In 2021, 5.0% of the population in Canada were **Indigenous people**, up from 4.6% in 2016.

First Nations people accounted for over half (58.0%) of the Indigenous population, while just over one-third (34.5%) were Métis and 3.9% were Inuit. (Statistics Canada, 2022a).

Indigenous populations continue to grow much faster than the national average, increasing by 9.4% from 2016 to 2021 (vs. 5.3% growth for the non-Indigenous population).

Large urban centres accounted for 12.5% of the increase in the Indigenous population (801,045 people) from 2016 to 2021. (Statistics Canada, 2022a).

“More than 70 distinct **Indigenous languages** are currently spoken by First Nations, Métis and Inuit people in Canada.” (Statistics Canada, 2021).

In 2021, 12.7% of the population spoke a **language** other than English or French predominantly at home, up from 2001 (9.7%).

There was strong growth in the number of Canadians who spoke a language from South Asia, as well as Mandarin, Arabic and Tagalog, predominantly at home. (Statistics Canada, 2022b).

“**Racialized groups in Canada are all experiencing growth**. In 2021, South Asian (7.1%), Chinese (4.7%) and Black (4.3%) people together represented 16.1% of Canada’s total population.” (Statistics Canada, 2022c).

One-quarter (23.0%) of the Canadian population were **immigrants** in 2021.

Immigrants tend be healthier than non-immigrants, but as they spend more time in Canada, their health deteriorates. (Statistics Canada, 2023a).

“Most of the Canadian population reported their **sexual orientation** as heterosexual (95.2%), while 1.8% of the population reported being gay or lesbian and 2.7% reported being bisexual or pansexual.” (Statistics Canada, 2023a).

“Most of the population aged 15 and older were cisgender, people whose **gender** corresponds to their sex at birth (99.7%).

Additionally, 0.3% of Canadians aged 15 and older, or 1 in 300 people, were transgender (people whose gender does not correspond to their sex assigned at birth) or non-binary (people who are not exclusively a man or a woman).” (Statistics Canada, 2023a).

In 2021, over 19.3 million people reported a Christian **religion**, representing just over half of the Canadian population (53.3%). This proportion is down from 67.3% in 2011.

The proportion of Canada’s population who reported being Muslim, Hindu or Sikh has more than doubled in 20 years – Muslim 4.9%, Hindu, 2.3%, Sikh 2.1%. Approximately 1% of Canadians reported Jewish affiliation and 1% reported Buddhism as their religion.

More than one-third of Canada’s population reported having no religious affiliation or having a secular perspective. (Statistics Canada, 2022c).

Canada’s population is **growing and aging**. From 2016 to 2021, the population of Canada increased by 5.2%.

By 2068, more than one in four people will be aged 65 and older. (Statistics Canada, 2023a).

“In 2022, according to Canada’s Official Poverty Line, the poverty rate was 9.9%, and about 3.8 million people living in Canada were in poverty.

In addition, racialized persons were more likely to live below the poverty line in 2022 (13.0%) than non-racialized persons (8.7%)." (Statistics Canada, 2024).

27% of Canadians aged 15 years and older, or 8.0 million people, had one or more disabilities in 2022 that limited them in their daily activities.

The rate of **disability** in Canada has increased by 5% since 2017, when 22% of Canadians, or 6.2 million people, had one or more disabilities.

This increase can be partially attributed to both the aging population and the large increase in mental health-related disabilities among youth and working-age adults. (Statistics Canada, 2023b).

Health inequities

Canadians are among the healthiest people in the world.

However, the benefits of good health are not equally enjoyed by all Canadians.

"Many of these inequalities are the result of individuals' and groups' relative social, political, and economic disadvantages. Such inequalities affect peoples' chances of achieving and maintaining good health over their lifetimes" (Public Health Agency of Canada, 2018).

Data shows that:

- Stigma, prejudice, and discrimination experienced by transgender and non-binary people have been found to affect their health status.
- Experiences of racial discrimination are connected to worse mental and physical health.
- The various impacts of colonization, subsequent intergenerational trauma, systemic inequities related to social determinants and discrimination have all played a role in negatively affecting the health of Indigenous people.

  (Statistics Canada, 2023a)

Recent research found that a higher proportion of visits to emergency departments and urgent care centres by First Nations patients were more likely to end with them leaving without being seen or against medical advice than those by non–First Nations patients.

First Nations patients' experiences of racism, stereotyping, communication issues, transportation barriers, long waits, and being made to wait longer than others were reasons for leaving.

Leaving early may delay needed care or interfere with continuity of care (McLane et al., 2024).

Dimensions of identity

As seen, Canada has much diversity, or differences amongst individuals.

These differences are present in a variety of visible and nonvisible areas such as gender, religion, sex, ability, and socioeconomic status.

These dimensions of identity intersect with broader contexts and influence an individual's beliefs, experiences, and values (COTO, 2022).

The framework of **intersectionality**, originally coined in 1989 by Kimberlé Williams Crenshaw, promotes an understanding of individuals as shaped by the interaction of different social dimensions or locations.

These interactions occur within a context of connected systems and structures of power (Hankivsky, 2014).

Beyond our differences, it's the structure of our broader systems that disproportionately oppress some intersecting groups including, but not limited to, those who identify as Black, Indigenous, racialized, 2SLGBTQIA+, disabled, neurodivergent, women, newcomers, older adults, impoverished, or people living with mental health conditions.

These oppressions have a persistent impact on physical, physiological, and mental health of people, including shorter life span, harms caused by violence, denial of services, and increased chronic illnesses (Alvarez et al., 2016; Krnjacki et al., 2016; McGibbon, 2012) (CAOT, ACOTUP, & ACOTRO, 2024)

Power and privilege

We each have our own **social location**. It's a position that one holds within society based on their intersecting identities.

"An individual's social location affects their experiences and can create certain privileges and/or disadvantages" (COTO, 2022, pg. 19).

A note about power and privilege: Power isn't about might – in this context, it's the ability to influence and make decisions that impact others.

Privilege is advantages and benefits that individuals receive because of social groups they are perceived to be a part of (Office of Pluralism and Leadership, 2024).

There is an inherent power imbalance that exists amongst institutions, groups, and individuals, which is present in the therapeutic relationship.

While there are power imbalances due to socially structured disadvantages, in an occupational therapy context, this power imbalance can also be influenced by factors between the client and the therapist such as differences in:

- health knowledge;
- social location; and
- communication abilities and styles.

The impact of power imbalance can be seen in:

- decisions about client health care needs;
- experiences that clients and caregivers have with the health system; and
- health status and outcomes.

PAUSE. There is *always* an inherent power imbalance in therapeutic relationships. Can you recognize it with clients and families you work with?

If you work in a non-clinical role… what power imbalances exist in your practice? Think about the power dynamics that exist, for example, between management and staff, researchers and participants, educators and students.

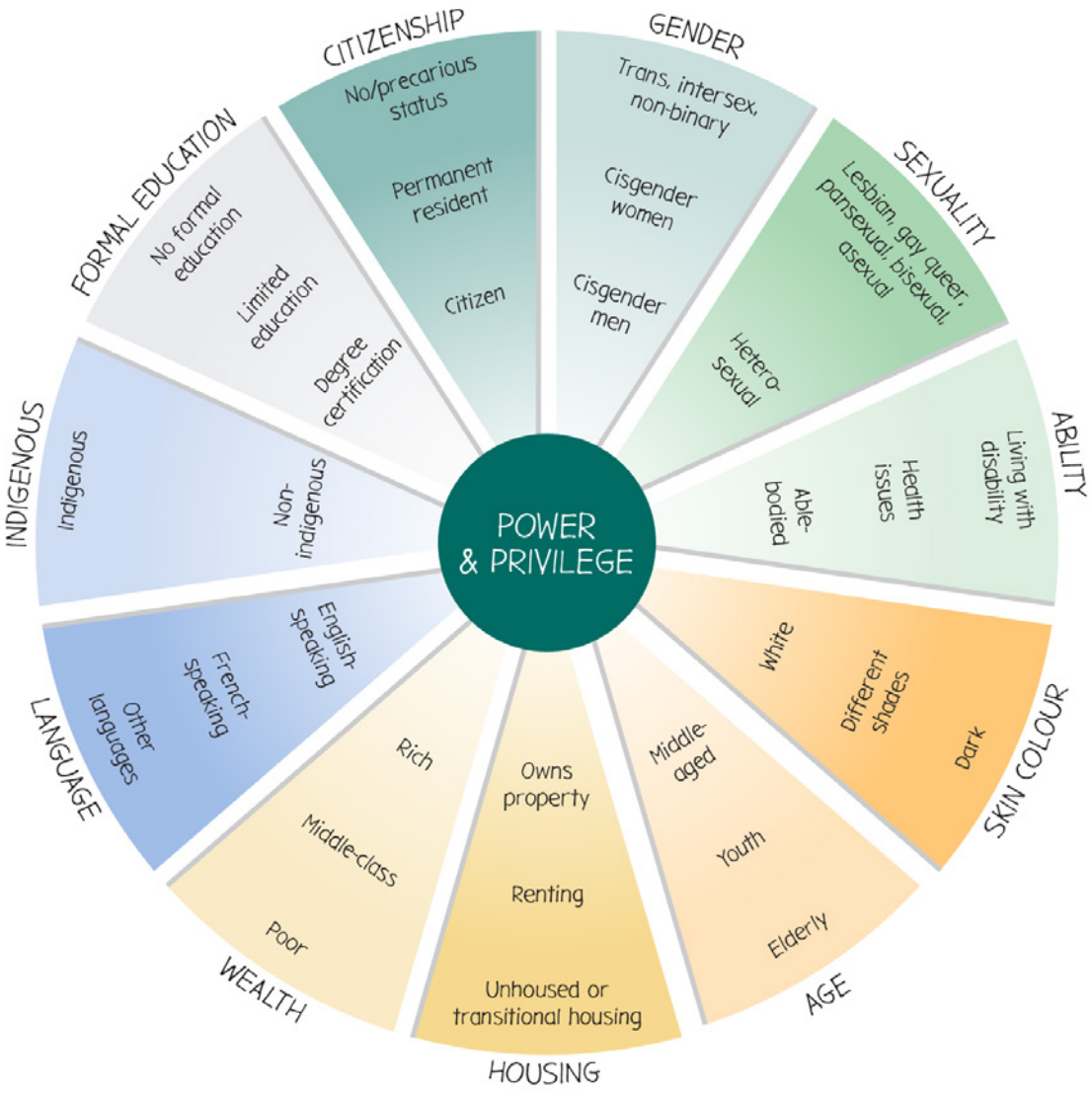
It is acknowledged that a power imbalance exists between regulators and registrants, which can influence how this eLearning module is received.

In recognition of this imbalance, we worked alongside OTs in practice to develop this module. We also heard and reflected the voices of clients and their families.

We have grown along the way—with still much to learn.

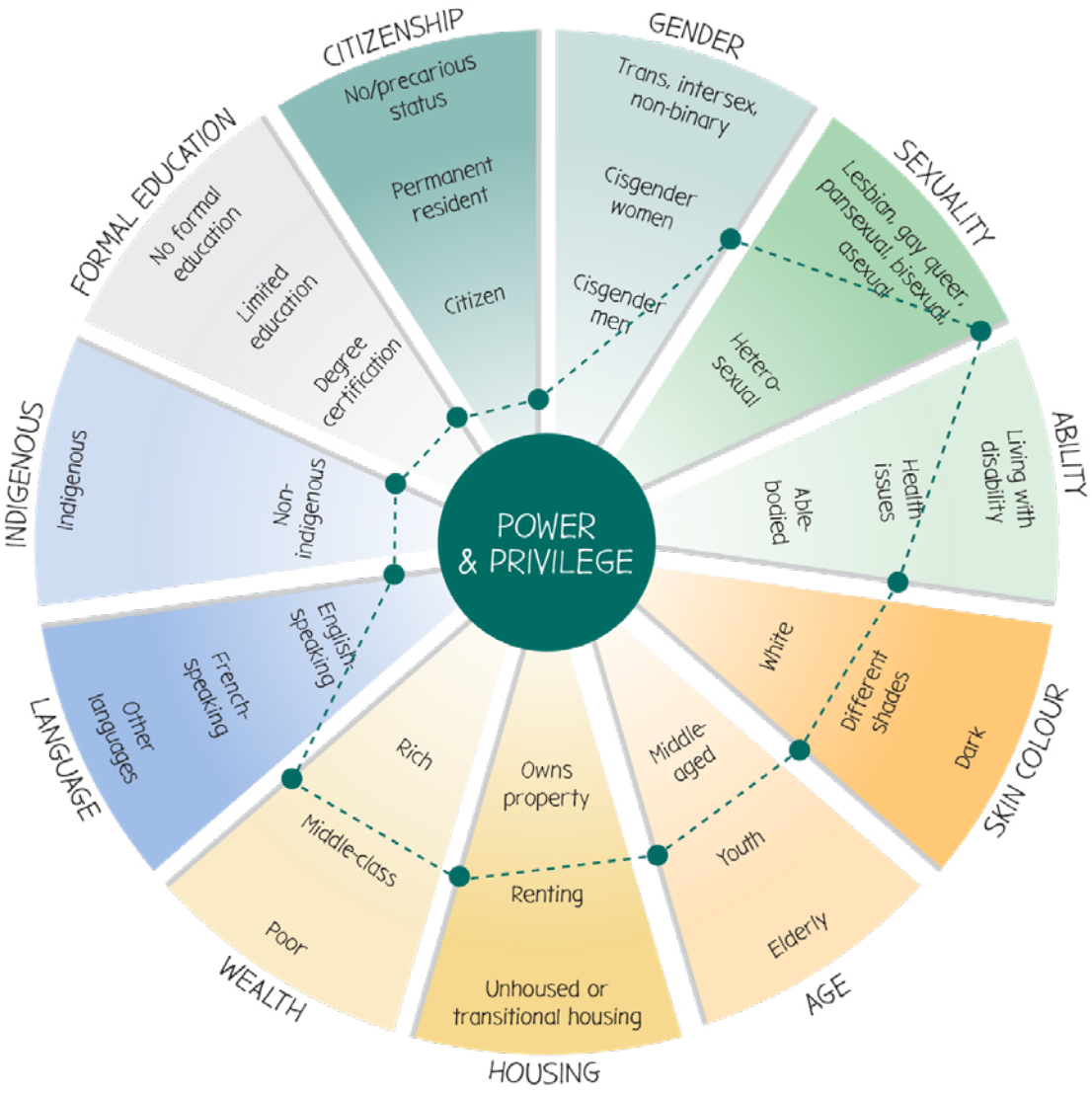
PAUSE. Take a moment to think about the identities <u>you</u> hold and how they relate to <u>your</u> social location.

Social location

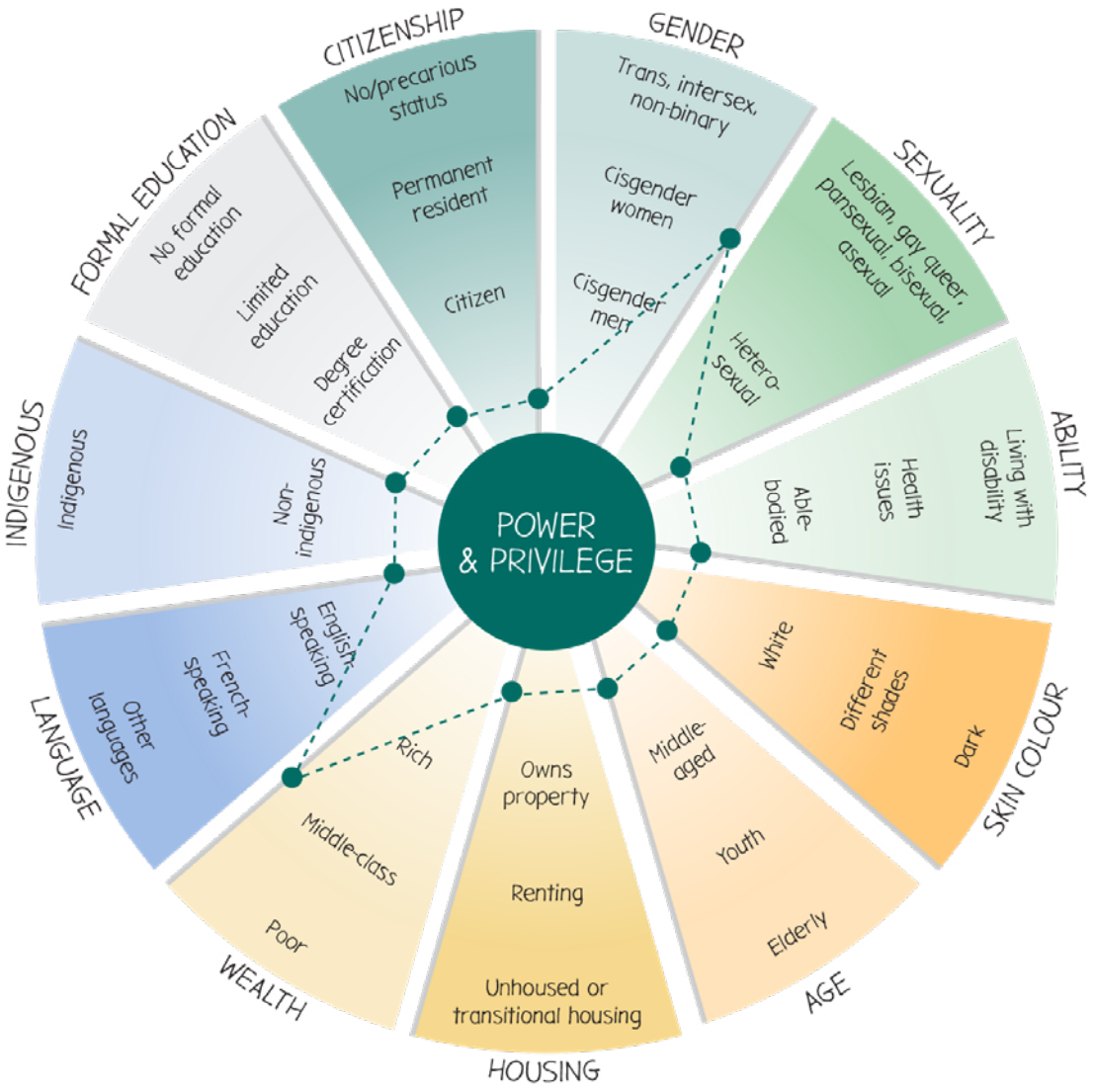


This wheel image shows some dimensions of identity (but not all). Use it as a guide to find out where you are located when it comes to power and privilege. We invite you to look at each dimension and consider which description fits your identity best. This is a way to show proximity to power and privilege.

For example, does your identity show that you are located <u>closer</u> to power and privilege:



Or does your identity show that you are located both close to and far from power and privilege:



Or are you still thinking about your social location?

If so, that's okay.

We may be at different stages of exploring our identity as it relates to power, privilege, and occupational therapy practice.

Social location examples

Now that you've reflected on your social location…

What impact does your social location have on <u>your</u> daily work?

Here are three examples to help get you started.

Example: cardiovascular rehabilitation program

An OT working as a manager is developing policies related to accessing a cardiovascular rehabilitation program where clients must attend the clinic in person for services.

The social location of the OT differs in both age and ability of the client population of the cardiovascular program.

The OT wonders what impact their policy decisions have on those that don't have the use of a car or are unable to use public transportation easily.

Example: long-term care home

An OT working in Nunavut, contemplates making a recommendation for a client to be moved to assisted living or a long-term care home.

Among other differences in social location, the OT is not Indigenous.

They recognize that this is not a simple solution as many communities in Nunavut do not have local access to these facilities. Moving a family member may mean moving them to a city far away like Edmonton, Winnipeg, or Ottawa.

The OT considers how they support the client and family through these difficult decisions.

Example: mental health group

An OT is developing the curriculum for a culturally specific education group on mental health and depression.

The social location between the OT and the participants differs in language and citizenship.

The OT is learning about the long-standing stigma and beliefs surrounding mental illness – all of which will make a difference when deciding on things like the name of the group, content and ways to promote the group.

Social location

Social location and <u>your</u> work

Think of the individuals and client groups that you work with. In which ways may their social location be similar or different from yours? What impact may this have on the services you provide?

Bias as a barrier

Research suggests that healthcare providers discriminate based on identity characteristics such as race, weight, and mental illness (Agner, 2020).

Our views and biases based on someone's social location can influence the quality of service we provide individually, and as an organization.

Biases can be:

- emotional – causing prejudice;
- cognitive – causing stereotypes; and
- behavioural – causing discrimination.

  (COTO, 2022, pg. 5).

The reality is… we all have biases, and they are inevitable and often harmful. We put others into categories based on characteristics like gender, age, race, ability, and ethnicity.

This can lead to inaccurate perceptions about the people we categorize, causing implicit bias as well as the potential for clinical decisions influenced by those biases (Luther & Flattes, 2022).

The good news... unlearning biases starts with acknowledging we have them and becoming more self-aware.

Let's look at some examples to build our awareness.

Bias as a barrier – conformity bias

Do you recognize any of these common biases?

Conformity bias, or "group think" happens when our individual opinion is swayed to agree or align with group views as a way of seeking acceptance (Todt, 2023).

For example: An OT is part of a working group to develop a new geriatric assessment. The assessment is very comprehensive and will take a long time to administer in the clinic. The team agrees that it needs to be shortened.

Most members of the group agree that the questions related to sexual health can be removed saying that "it's probably not going to apply to the majority of our clients".

This seems like a generalization based on age and you don't believe that to be true, but to move the project along, you go along with the decision and think "something has to be removed so it makes sense to just agree".

Bias as a barrier – confirmation bias

Confirmation bias: The tendency to lean toward evidence that supports our opinions, giving it greater weight (Todt, 2023).

For example: An equipment vendor thinks that clients with low income and disability, who use publicly funded equipment, are time-consuming and hard to follow-up with.

They assume purchase and repair issues are more difficult to resolve and because of this bias, repairs can be delayed or ignored, which puts these clients at risk.

Bias as a barrier – affinity bias

Affinity bias: A preference for people who look like us or share other qualities (Todt, 2023).

For example: An unexpected and highly sought after appointment becomes available in the clinic schedule. There are two clients that could equally benefit from an earlier appointment for new seating and mobility equipment as they both have the same risk of tissue injury.

One client is similar to you in age and profession, the other client is older and differs in ethnicity and language.

If clients who are most similar are prioritized for appointments, it's worth reflecting to see if affinity bias played an unconscious role.

Bias as a barrier

PAUSE. Biases—we all have them. Thinking back over the last few weeks, where have biases shown up in the work that you do?

Section 3: Advancing Change

Client voices:

Valuing the person

Intentional communication

Building rapport

Shared decision making

Collective approaches

Occupational therapists – awareness and change

Promoting occupational participation requires an understanding of the uniqueness of each client. Occupational therapists "help to solve the problems that interfere with a person's ability to do the things that are important to them" (CAOT, 2024).

The threads of culture, diversity, lived experience, and socially structured disadvantage are woven into identities and influence the activities people have access to and consider important in their lives.

We also incorporate identity into our work.

As OTs, we listen, we gather information, we group, we analyze, we share, and we plan. Each time we do these things, we are offered an opportunity to show humility with clients, caregivers, the larger workplace and beyond.

OTs are perfectly positioned to advance change.

> *All must take responsibility for their part in realigning occupational therapy for the future. Different people, by virtue of position, experience, and privilege, will have differing opportunities to implement aspects of social accountability and advance equity and social justice (CAOT, ACOTUP, & ACOTRO, 2024, pg. 3).*

Advancing change – strategies

"If you change the way you look at things, the things you look at change." Wayne Dyer

Occupational therapists – awareness and change

Awareness through self-reflection is the first step for creating a culturally safer and inclusive client experience.

What does this look like? Intentionality is key.

As a starting point, shift your attention and begin noticing your own cultural views and interpretations. You've already started this in the previous exercise by:

- identifying your social location;
- considering how your social location may differ from clients; and
- reflecting on the power imbalance in the therapeutic relationship, your workplace and beyond.

Client experiences

We asked a diverse group of clients and caregivers questions about their occupational therapy experience, including:

- *What did the occupational therapist do or say to make the experience inclusive and safe for you?*
- *In which ways did the occupational therapist include your cultural practices and preferences?*
- *What are some of the ways that health care providers can be more open, curious and inclusive with clients?*
- *If your experience with an occupational therapist did not feel safe or inclusive, please describe.*

Advancing changes – strategies

Clients and caregivers offered their experiences along with valuable suggestions on what aspects of the occupational therapy service were helpful and what can be improved.

These are summarized into four main strategies:

- Valuing the person;
- Intentional communication;
- Building rapport and trust; and
- Shared decision making.

Let's first hear what clients and caregivers had to say about valuing the person.

Valuing the person

"The OT seemed genuinely interested in getting to know my mother, her preferences, her healthcare journey, her needs, her concerns etc.

They saw my mother as a person first with unique needs, not simply an unwell patient.

The OT asked what was most important to my mother and our family in terms of cultural practices and preferences."

"It is important that providers see a client as a person first and an illness second.

Humans caring for humans.

Providers need to get to know their clients with an open mind and put their assumptions aside."

"Demonstrating comfort and competence and confidence in providing treatment and goal planning for all ages, religious beliefs, gender, orientation, race and abilities."

"Health care providers can try to be 'in the moment' and present with clients, treat them as unique individuals and reassure them that both the OT and the clients can collaborate to help make their lives easier and manageable.

I think some open-ended questions could be asked of each client:

What do I need to know about you?

How can I best help you?

What might not be helpful for you?

The OT can carefully listen to the answers, ask any needed follow-up questions and take direction from the answers."

Leave assumptions behind and approach each client with openness and curiosity.

Lead with humility to create an environment where the person and family's lived experience is a valued and integral part of the occupational therapy assessment and intervention process.

This approach supports better client experiences and health outcomes.

Intentional communication

"I do want to make sure that my gender name preferences are used and sensitivity is paid attention to my needs as a person who identifies as nonbinary.

So, I prefer that sir, gentlemen not be used when calling me.

I prefer my first name as it does not fit me within a certain gender.

Be willing to learn, learn, learn.

Ask your clients in a positive way, if you are uncertain about wording. i.e., if you have a transgender client; what pronouns do you identify? What is your preferred name?"

"My OT asked permission to touch me and let me know how/why they were doing it. Explaining what they were doing every step of the way was very respectful."

"The OT would talk really loud (English is my second language) and maybe because they think all 'older' adults cannot hear, it feels like they are shouting.

The way they think they are making the experience inclusive makes it even worse for me...it can lead to communication breakdown and hence safety can be at stake."

"Sometimes the OT would make an effort to pronounce my name correctly, often they will not even acknowledge if they said it wrong."

"Health care providers must improve their listening skills in order to understand the lived experience of their client and what their needs really are.

They must remain unbiased in their interactions with clients."

Verbal and nonverbal communication techniques can be intentionally used to promote safety and inclusivity.

Gestures and facial expressions that express interest, reflective listening and open-ended questions are just a few ways that communication can help send a feeling of openness to people within our workplace.

Workplaces are busy and OTs are purposeful in making space to listen and hear what is being said (and not said) by clients so true cocreation of the therapeutic experience can happen.

Being alert to cues from clients and asking questions can help OTs to learn more about cultural practices, preferences, and perspectives.

Building rapport and trust

"When various elements of an individual's life are taken into consideration such as ethnocultural, religious practices and/or certain beliefs, it can change the perception in the care in which they are receiving.

If someone has the sense all elements of their lives are heard by the clinician it is easier to establish rapport, compliance to treatment and therefore outcomes."

"Feeling safe and respected is key when working with any health care provider, it leads to greater outcomes for the patient.

I feel my experience with my OT was a positive one and helped me recover from my accident."

"They can start by building a rapport with the client, understanding where they are from, languages they speak, what are their hobbies, ask about family, any particular challenges they have, what the OT can do to help while doing treatments, if they had any challenges getting to the appointment e.g., client may have had to walk to the appointment, if they had any challenges financially—this information would be readily available if they had good rapport with the client.

Try and find a common ground."

Good therapeutic rapport impacts how clients experience the service, participate in the assessment and intervention, and achieve their occupational performance outcomes.

Trust is the foundation when building rapport and supports clients to feel heard, understood and valued.

Shared decision making

"The occupational therapist was very empathetic with my parents who did everything for me growing up and were overprotective. My mom especially was against me moving out on my own because she did not feel that I could physically cope due to my limitations.

The OT took all of my mom's concerns into consideration and included her in the solution process. She really helped my parents to understand that I can succeed on my own with minimum assistance and ingenuity.

I was in awe of her ability to help my parents to accept my decision to move out. I moved out a few months later and have lived a successful and independent life."

"The OTs spoke to my mother with genuine interest and concern.

They demonstrated no ageism and acknowledged that my 92-year-old mother best knew her body and capabilities."

"Listening to what my needs are regarding therapy and how to engage in that in an appropriate and sensitive manner."

Some clients may defer to the occupational therapist as the "authority" or "expert" when making treatment decisions because of the inherent power imbalance present in the therapeutic relationship or cultural preferences.

Use co-creation strategies that encourage all voices to be heard.

Listen to learn, so clients and their caregivers play an active role in making decisions about their health and the services they encounter.

Talking about options and choices encourages clients to voice their priorities and preferences about therapeutic decisions.

Organizational and system strategies

In addition to the direct clinical strategies described in the previous slides, there are many other ways in which occupational therapists can influence client experiences, many of which apply to both clinical and non-clinical occupational therapy roles.

The *Joint Position Statement: Towards Justice. Enacting an intersectional approach to social accountability in occupational therapy* (CAOT, ACOTUP, & ACOTRO, 2024) provides examples of recommendations to advance equity and justice. Here is a small sample of strategies from this resource:

- Contribute to workplace cultures that are open to new ideas;
- Identify how systems of oppression can show up in “how things are usually done”;
- Promote culturally safer spaces and spaces of belonging;
- Review policies, protocols, and forms to ensure that they do not disadvantage or exclude certain groups
- Promote access to environments and resources to increase occupational participation;
- Establish equity indicators and outcomes with local underserved groups;
- Offer opportunities for co-creating initiatives; and
- Ensure culturally safer recruitment and retention practices.

Section 4: The Exchange

Scenarios

Strategies

Reflective questions

The Exchange

Learning from each other

As you go through each scenario, you are encouraged to think about the role of factors such as social location and power, cultural view and assumption, bias, stereotype and discrimination, systems of oppression and importantly – how OTs can reflect and advance change.

Self reflection

OTs have provided these real life examples. After each scenario there are reflective questions offered, many of which are from the Culture, Equity, and Justice in Occupational Therapy Practice document (COTO, 2022).

This introductory resource by the College of Occupational Therapists of Ontario may help you to apply to practice the principles of Domain C: Culture, Equity, and Justice of the Competencies.

1. In my practice

Age: more than just a number

I work as an occupational therapist within a multidisciplinary team in the adult mental health program at our local hospital. In the inpatient program, I run brief behaviour-based groups and do functional assessments. In the outpatient program, I lead in-depth process-based groups with people. Often patients will transition from the inpatient to the outpatient service, as they become more stable.

In our in-patient team rounds, there was a discussion about the discharge options for an older adult that was on the unit. Opinions varied within the team about if it was appropriate for the patient to be referred to the outpatient program, as some thought the patient was “too old” for the content and wouldn’t fit well with other members of the outpatient group.

Some team members thought that this patient may not get the same benefit as younger patients, as the group discussions often center around work and family situations. After some debate it was decided that the patient would be referred to outpatient services, but the decision was questioned by some, including me.
This client ended up being the oldest person in the outpatient group by many years. She listened to the struggles and strategies that group members shared and contributed meaningfully to conversations with her own wisdom and experiences.

What I saw unfold was an important therapeutic bond between this patient and a young member of the group. Both had been estranged from their family of origin. The group helped each to heal from previous family experiences and gain confidence and skill to form healthy relationships.

Individual strategies

Self-reflection. This taught me a valuable lesson about the judgment I make about clients based on assumptions that I previously held about age.

Thankfully, in this example, the client accessed the service, however, it was a reminder that there could have been a poor outcome for the client had she not been offered the spot in the day program and ended up isolated and declining at home.

Valuing the person. Initially I saw the patient as a “very old person” instead of objectively looking at her needs and how she could benefit from meaningful connections and acquiring new skills through the group.

Collective approaches: organization and system strategies

- Review the inclusion and exclusion criteria for programs with an inclusiveness perspective;
- Develop programs and content that are welcoming and inclusive for all; and
- Ask questions to identify if bias or cultural assumptions are guiding program and organizational decisions about access.

Reflective questions: in your practice

What positive and/or negative assumptions do I make about specific groups?

What stereotypes do I subscribe to?

What informs these assumptions and stereotypes?

2. In my practice

Judging a book by its cover

I work at a hospital as an occupational therapist on a general medicine floor. There is a man with frequent admissions to the program. He is well known to the healthcare staff, and they are aware that he is unhoused and lives in a nearby park.

When listening to staff members discuss this patient, they have voiced their assumption that his living situation is due to poor life choices, addiction, or mental health issues. This may or may not be accurate. Regardless, assumptions have led to judgment, and staff interact differently with him. Clinical interactions with him appear fewer and shorter, and sometimes staff have an abrupt tone that signals annoyance. He is asked fewer questions and staff have made assumptions about his needs, goals, and plan of care. Although hard to admit, we have not provided him with the same level of service as other patients.

Individual strategies

Self-reflection. Observing this prompted me to reflect on my thoughts and behaviours towards those who are unhoused. I have been thinking about the ways that I may also be contributing to his health inequities by what I do, or don't do, as part of his assessment or intervention.

As a provider, I ask…

"What impact do my assumptions have on his health and well-being?"

"Am I going along with 'group think' (conformity bias) because it's become the normal way of interacting with this patient?"

"Am I making assumptions about his priorities and quality of life?"

"What do I need to unlearn to provide equitable service?"

Intentional communication. Team rounds have helped me to be more objective, as I listen to the resources available to patients and I purposely consider if we have overlooked services that are offered to others.

Speaking up to advocate requires a change on my part too.

I have more awareness in the way I speak to patients including my attention, tone, and curiosity. I ask and listen openly to his goals and preferences. Taking a curious approach means that I need to allow more time to listen and explore what I may not know about this patient.

I recognize that bias may influence my recommendations, and I keep his goals at the center of the occupational therapy intervention.

Collective approaches: organization and system strategies

- Notice and name ways in which the program and service may be contributing to oppression;
- Advocate for access and resources for those who are underrepresented;
- Co-create services that include representatives from a range of service users; and
- Prioritize a diverse representation at all levels of the organization.

Reflective questions: in your practice

Who is likely to feel welcome in my practice setting?

Do the values, philosophies and goals of my practice setting align with those of the current population that I am providing service to?

In what ways do I create ethical spaces to better understand my client as a person, including their unique social location, worldviews, beliefs, and values?

3. In my practice

Words matter

I work in a hospital and often, the family caregivers will be present in the patient rooms. I recently went to meet a patient so I could begin the OT assessment. I introduced myself by name and asked how the patient was doing. The caregiver replied “no offence, you look like a nice person, but my dad just can’t understand accents. Is there someone else who can work with him?” This caught me off guard and I immediately felt the need to prove that “I’m from here”.

Individual strategies

Self-reflection. Reflecting on my own intersectionality helps to process these types of interactions. I consider my social location and what identities I hold in relation to others, for example, an occupational therapist, visible minority, and person who speaks multiple languages.

I draw on our commonalities as part of the therapeutic relationship.

Intentional communication. It is easy to react to these types of comments and I have learned from experience, that having a conversation to find out about the specific concern is a good first step.

I catch myself before making assumptions about the intent, so I pause to try and figure out what’s behind the comment. Sometimes it could be related to a sensory or cognitive issue, or there may be personal factors that add some context.

I may say something like *“Staff are assigned to patients, so let’s see what we can do to make this work. Tell me about your dad and any tips you have when we are talking to each other.”*

Communication may also involve sharing this experience with colleagues and supervisors so they are aware of the challenges staff may encounter and can help address them at additional levels.

Collective approaches: organization and system strategies

- Share and discuss the anti-discrimination policy; and
- Co-create safe processes in which to report workplace experiences.

Reflective questions: in your practice

Based on my own experiences, do I feel safe at work?

Have I experienced discrimination, inequity, or oppression because of my social identities?

Do I have a plan to manage these experiences if they occur with my clients, colleagues or elsewhere in my workplace?

4. In my practice

Divided by differences

Some time ago, I received a referral to assess for a therapeutic mattress in a client's home. During the assessment, the client said that it was common practice for her and her family, as part of her culture, to sleep on the floor. I talked with her and her family to explain the risks to her skin integrity but with her inability to shift positions, she developed pressure ulcers on the hard surface.

Preference and cost factored into her decision to decline the hospital bed recommendation, and she was deemed "non-compliant". Declining the hospital bed made her ineligible for the pressure relieving mattress and because transfers from the floor were deemed unsafe, some personal care and OT services were limited. Some wound management options did not fit within protocols. The client's condition continued to decline significantly.

Individual strategies

Self-reflection. I see how multiple systems and processes contributed to this situation.

I learned that sometimes doing things the "usual way" can be harmful instead of helpful to clients.

I learned that these systems may lead to health inequity and detrimental outcomes for people who don't fit within Western norms and practices.

Intentional communication. In hindsight, I wish I had done things differently and established a better understanding of the client and the reason for the sleeping arrangement.

While cultural preference was a factor, other influences such as cost, ease, or safety could have been more fully explored. Maybe I could have advocated for additional visits or inquired about alternative ways that equipment could have been provided.

Collective approaches: organization and system strategies

- Support a culture of accountability and an openness to explore "how things can be done" instead of "how things are done";
- Review policies, protocols, and forms to ensure that they do not disadvantage or exclude certain groups; and
- Incorporate curriculum to address these barriers for those who are teaching in OT programs.

Reflective questions: in your practice

Do I consider my client's experiences, worldviews, contexts, and beliefs about health and occupation when selecting practice tools and approaches?

What barriers exist to accessing the services I provide? Are there cultural, economic, physical, political, or social obstacles that should be addressed?

How can I help to make available services more accessible?

5. In my practice

Listening to learn... learning to listen

I work in the auto insurance sector with people who have been in car accidents. A colleague asked if she could transfer a client to me saying “they have plateaued, and you don’t need to do much more treatment with them. They should be ready to discharge soon”.

The client was transferred to my service, and I went into the first session expecting to confirm what I had been told by my colleague and prepare for discharge. It didn’t go as planned and I quickly learned that their assessment of this client was different from my own. I spent time asking, listening and learning about his Indigenous culture. We discussed the importance of his goals of participating in long house activities and helping with productivity and leisure tasks of hunting and fishing. With time and trust I learned about the nuances of what was important to him and only with this understanding could better incorporate these into meaningful intervention strategies. He began to experience changes and was encouraged! He felt heard and understood and shared that before this he had “no idea that occupational therapy could help me”. We worked together for more than a year figuring out our strategies and getting the equipment to fully enable his occupational participation.

Many factors contribute to good outcomes, but this experience was different from his previous one because of the trust and safety of the therapeutic rapport. He felt safe to share about his background which was valued and integral to the change process.

Individual strategies

Build trust and rapport. Clients want OT service that is effective, equitable and inclusive and these need to be explicitly demonstrated, especially in situations of systemic oppression and mistrust with the healthcare system.

There is a saying that “trust is gained, not given” and this is particularly relevant in this example.

Intentional communication. Asking open ended questions helps to better understand each client’s identity and related priorities and preferences.

It may be worth thinking in advance about culture related questions that you could incorporate in your specific practice so you can give thought to the most appropriate phrasing and choice of words. Clients may have input on how it was to be asked certain questions. Adapt based on what feedback you get from clients and their families.

It is okay to go from a place of not knowing to knowing.

Purposefully build bridges by exploring ways to learn about non-dominant world views as they relate to people you work with. Perhaps attend educational and cultural events to learn and understand about others relevant in your practice.

Collective approaches: organization and system strategies

- Explore meaningful ways to understand client lived experiences;
- Look for opportunities to participate in or share research to build awareness outside Western expectations of occupational participation; and
- Enhance curriculum about the therapeutic use of self and how to build trust in the therapeutic relationship especially related to cultural conversations.

Reflective questions: in your practice

Have I created time and space to understand my clients' lived experiences, values, beliefs, preferences, and worldviews?

How can I work with my clients to develop a service plan that is meaningful and relevant to them?

6. In my practice

What's in a name

I received a transfer referral for a client who told me they had a bad experience with the previous therapist who continued to mis-gender them throughout the service. After learning this, I started to wonder if the referral was directed to me because I identify as an out-queer person? Was the client assigned to me based on my identity?

In my opinion, all clients can feel safe and welcome when all occupational therapists are competent with gender identity conversations and approaches.

Individual strategies

Valuing the person. Our names and pronouns are an extension of our identity as individuals and as groups. We, as providers, make every effort to get it right. This includes attention to pronouns, pronunciations, preferences, and needs in how to address clients. Safe and effective service incorporates this knowledge into every aspect and step of the assessment and intervention.

Build trust and rapport. Effective, equitable and inclusive occupational therapy service is demonstrated by what we say and do. Trust in the therapeutic relationship happens when clients trust that information is valued and correctly incorporated into each interaction. Building effective rapport may involve unlearning of certain opinions, beliefs, attitudes, or behaviours.

Collective approaches: organization and system strategies

- Prioritize time for training and discussion for gender-affirming practices; and
- Promote culturally safer spaces and spaces of belonging.

Reflective questions: in your practice

How do clients want to be addressed and described (for example, name, gender, and pronouns)?

How do I model culturally safer, anti-oppressive, and equitable practices for others in my workplace, including colleagues and students?

7. In my practice

Back to basics

As a therapist in school-based pediatrics, I sometimes find myself jumping ahead to initial goal-setting conversations without taking the opportunity to really explore the student's living situation. I think about the hierarchy of needs and the foundation of physiological needs like housing, food security, and adequate sleep. By reflex, I reach into my toolkit to choose assessments and interventions that are familiar, particularly when demands are high, without pausing to critically reflect on my approach with each individual client.

I remember my first visit with a new student, who was diagnosed with cerebral palsy, where we set goals together related to activities of daily living within her school day. Over the school year, and as trust was developed with her and her caregivers, I learned that she often didn't have enough to eat, and their housing situation was precarious at best. I realized that the goals we had set could only be prioritized once her basic needs for food and shelter had been met. I continue to be reminded that the people I work with are complex and there is often more than what I initially see that is part of meaningful assessments and realistic recommendations.

Individual strategies

Valuing the person. A client is much more than what we initially see. First impressions are formed, and assumptions are made. Go beyond this. Allowing time and space to get to know each client gives an opportunity to find out about their reality and what that means for how to effectively work together. It's an integral part of our work.

Shared decision making. The best-intentioned plan can only be realized if it fits within the life circumstances for the client. One size doesn't fit all. OTs are well positioned to adjust and refocus the intervention to fit the realities of clients and their families.

Readiness is a process. We can gently encourage clients to take the lead at the pace that works for them and advocate as needed.

Collective approaches: organization and system strategies

- Contribute to research about the impact of social determinants of health on occupational participation and occupational therapy practice;
- Co-create assessment or intervention questions with cultural humility in mind; and
- Advocate for access to resources and additional service, for unmet needs of clients.

Reflective questions: in your practice

How can I work with my clients to develop a service plan that is meaningful and relevant to them?

What community partners can I engage with to address barriers and inequities in health and occupation? How can I build and/or strengthen these relationships?

A new awareness

It is our hope that this module, especially the scenarios, brought a new awareness of cultural humility in occupational therapy practice.

> *Eyes see only light, ears hear only sound, but a listening heart perceives meaning.* — David Steindl-Rast

Contributions

Thank you to the many contributors—especially to those individuals that shared their own experiences.

Contributors included clients and caregivers, occupational therapists, researchers, academics, educators and other experts in equity, diversity, and inclusion.

Thank you

"The profession of occupational therapy envisions a healthier and more inclusive world in which people participate in occupations without systemic barriers, injustices, and deprivation. Individuals must discern their own starting points and next steps to advance equity and accountability" (CAOT, ACOTUP, & ACOTRO et al., 2024, pg. 7).

As a lifelong learner, we hope this module provides new learning that inspires opportunities for reflection and change in Canadian occupational therapy practice.

Thank you for participating.

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